Provider Manual

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Introduction to Alliant Health Plans

For nearly 15 years, Alliant Health Plans has been a leading provider of health care insurance in Georgia. Our not-for-profit company was founded by health care providers with a distinct goal: to focus on the overall health and well-being of our clients and service them proudly, with honor and integrity. In looking to better our practices and improve how we work in the future, Alliant Health Plans has created an entirely new approach to health care. By putting doctors in charge of treatment decisions, and patients ahead of profits, we are returning medicine to its original purpose of healing.

Alliant Health Plans is a licensed Provider Sponsored Health Care Corporation (PSHCC) striving to offer optimal health care to our policyholders. We accomplish our goal by including physicians and community leaders on our board of directors, in order to determine how to best deliver care to the communities we serve. Alliant offers health plans for businesses and individuals.

Provider Manual

This manual was developed as a guide to assist providers with daily operations. Alliant Health Plans will comply with the laws of the state in which it operates. The provider manual can be found by accessing our website www.alliantplans.com.

Disclaimer

Alliant Health Plans has covered numerous topics in this manual, however, it is not all-encompassing. In addition, the information provided is subject to change as updates, revisions and additions occur. Users are encouraged to regularly visit www.alliantplans.com for the most up-to-date information.

Payable benefits, if any, are subject to the terms of the policy in effect on the date the service is rendered. In the event of any inconsistency between this manual and Georgia State law, state law supersedes.

Key Term

For the purpose of this manual, any reference to the term "Member" means any employee, subscriber, enrollee, beneficiary, insured or any other person, including spouse or dependents, who is eligible to receive benefits under an Approved Plan.

How to Contact Us

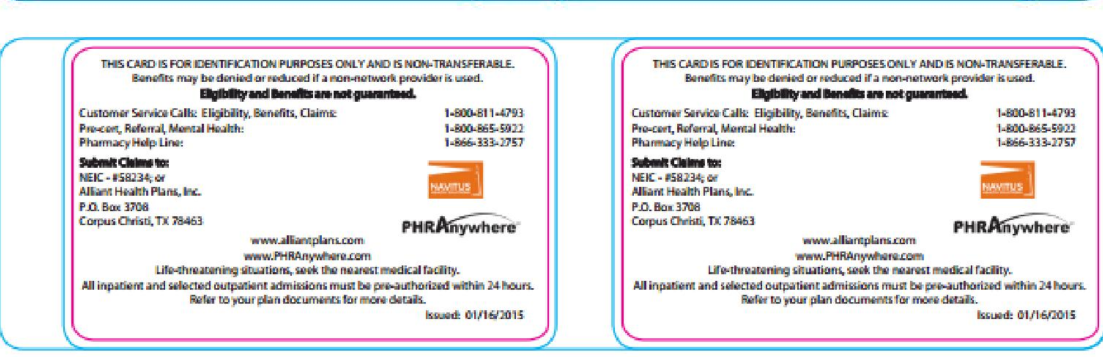
Customer Service • **Benefits** • **Eligibility** • **Claim Status**	P: 1-800-811-4793 Business Hours: 8:00 am to 5:00 pm (EST) *(Online Eligibility, Benefits and Claim Status are available by registering for our online service. Please see* ***Web Resources*** *below.)*
Prior Authorization/Pre Certification	P: 1-800-865-5922 F: 1-866-370-5667 Business Hours: 8:30 am to 5:00 pm (EST) On-call 24 hours per day/7 days per week Address: Alliant Health Plans Medical Management Department 5 Neshaminy Interplex, Suite 119 Trevose, PA 19053 *(Prior Authorizations are also available online by registering for our online service. Please see* ***Web Resources*** *below.)*
Claims • **Electronic Claims Submission** • **Paper Claims Submission** • **Claim Appeals**	Address: Alliant Health Plans, Inc. P.O. Box 3708 Corpus Christi, TX 78463 Payor ID #58234 Clearinghouse: Change Healthcare *(Alliant Health Plans also offers Electronic Funds Transfer (EFT). Please contact Provider Relations at 1-800-664-8480 or providerrelations@alliantplans.com to set up this service.)*
Provider Relations	1-800-664-8480 or providerrelations@alliantplans.com

Provider Resources

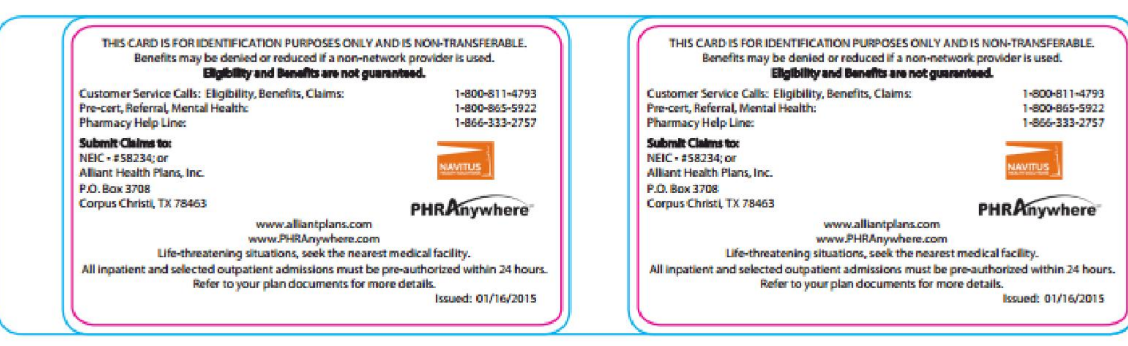
Member ID Cards

Providers should confirm Member eligibility and benefit coverage prior to rendering services since individual Member benefits will vary. Please refer to the Member's ID card for the resources available to assist in obtaining this information.

Employer Group with PHCS

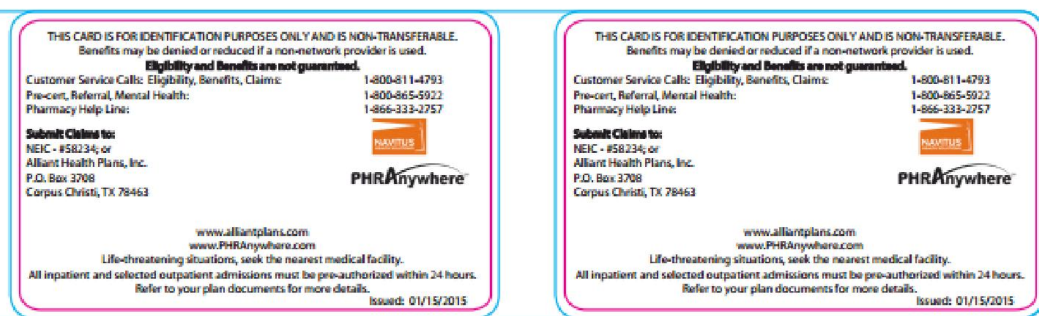


SoloCare – purchased OFF the Marketplace



SoloCare – purchased ON the Marketplace

PHCS Primary Network



SoloCare with no PHCS

Front of the Card

Group Name	Name of employer group that holds the policy or plan
Group ID#	Unique ID # for the employer
Member Deductible	Member individual and family deductible
Member Copay	Copay may vary for PCP or specialist
Urgent Care Copay	Urgent care copay
Rx Copay	Pharmacy benefit copay
Member ID#	Privacy number for the Member
Effective Date	Effective date when coverage begins
Member Name	Name of Member
Rx Group #	Used by pharmacies to submit claims through electronic clearinghouse

Please use the Member ID number, located on the front of the ID card, in all communications (telephone or written) with Alliant Health Plans. We are committed to protecting the privacy of the personal information of our Members.

Back of the Card

Customer Service	Phone number to reach eligibility, claims and benefits
Pre-Cert, Referral, Mental Health	Phone number to reach prior authorizations, referral or mental health
Pharmacy Help Line	Phone number to reach Navitus
Payor ID	Unique # for filing electronic claims
Claims Address	Address for submitting claims
PHR Anywhere Website	Web address to access Member's secure health record
Alliant Health Plans Website	Web address to access Alliant Health Plans

Logos on ID Cards

Alliant Health Plans	Corporate entity
PHCS	Nationwide network of health care professionals and hospitals accessed by Members when they travel and/or seek services outside Alliant Health Plans' network
Navitus	Pharmacy benefit management
SoloCare	Designates individual product
PHR Anywhere	Secure online access to Member's health record

Customer Service Telephone Numbers

Our primary customer service number is: 1-800-811-4793. Use this number to inquire about eligibility, benefits and claims. Eligibility status can be obtained through our automated phone system or via online access 24 hours per day/7 days per week.

Utilization Management Telephone Numbers

The prior authorization, referral, and mental health service number is: 1-800-865-5922. Medical Management is available from 8:30 am to 5:00 pm (EST), and on call 24 hours per day/7 days per week.

Provider Relations and Credentialing

The Provider Relations service number is: 1-800-664-8480, available Monday through Friday from 8:30 am to 5:00 pm (EST). Contact Provider Relations to inquire about the following:

- Contracting
- Fee Schedules
- Provider Application/Credentialing
- EFT Registration
- Online access to eligibility and claims

Pharmacy Help Line

Alliant Health Plan Members have access to Navitus, a pharmacy benefit program. For assistance please call: 1-866-333-2757.

Specialty Pharmacy Help Line

Alliant Health Plan Members have access to Diplomat, our preferred vendor, for specialty pharmacy medications. For assistance please call: 1-877-977-9118.

Provider Web Resources

Providers can enjoy the convenience and time-saving benefits of our online resources by accessing www.allianthealthplans.com, which includes, but is not limited to, the following:

Real Time Member Eligibility, Benefit Verification and Claim Status	Providers have online access through https://alliant.abovehealth.com or visit alliantplans.com, select Healthcare Professionals, choose Provider Resources, and choose Provider Portal Log In – Above Health. To register, please contact Provider Relations at: 1-800-664-8480 or providerrelations@alliantplans.com.
Prior Authorizations	Providers have convenient access to online prior authorizations. To register, please access www.alliantplans.com, select Healthcare Professionals, choose Provider Resources, and choose Online Provider Portal Log In – Online Prior Authorization Submission in the Medical Resources section.
Fee Schedules	Providers have convenient access to fee schedules. To register, please contact Provider Relations at: 1-800-664-8480. For access, go to www.alliantplans.com, select Healthcare Professionals, choose Provider Resources, and choose Provider Portal Log In – Fee Schedule Application in the General Resources section.
PHR Anywhere (Virtual Member Unique Health Record)	Providers have convenient access to Member's health record. Please go to www.alliantplans.com, select Member Portal to be directed to PHRAnywhere. Registration may also be initiated by visiting this site.
Navitus	Navitusis the benefit pharmacy program. To access, please go to www.navitus.com.
Diplomat	Diplomat Pharmacy is our preferred vendor for specialty drugs. To access, please go to www.diplomatpharmacy.com.

Electronic Provider Directory

Alliant Health Plans maintains an electronic provider directory which allows clients, Members, and providers convenient access to information. Providers can use the directory to:

- Identify in-network providers for Member referral purposes
- Assist Members with provider questions

The electronic provider directory can be accessed by visiting www.alliantplans.com and completing the following steps:

- Click on Find a Provider
- Search by Provider Name, Specialty or Location as well as other demographic factors

Provider Directory Disclaimer: While Alliant Health Plans strives to ensure the accuracy of the information presented on this site and in the printable directory, the information is dependent upon providers notifying the network of additions, changes and terminations. Provider information and participation is subject to change and may vary from plan to plan. Therefore, providers should always

confirm their network participation prior to rendering services by calling the Alliant Health Plans Customer Service Department at 1-800-811-4793.

Provider Referrals

In order to assist in controlling unnecessary out-of-pocket expenses, providers are encouraged to refer Members to in-network providers. Assistance in finding an in-network provider referral can be obtained by calling Alliant Health Plans Customer Service line at: 1-800-811-4793.

Out-of-network providers are encouraged to contact Alliant Health Plans at: 1-800-664-8480 or providerrelations@alliantplans.com to inquire about becoming an in-network provider.

Provider Credentialing & Records

Credentialing

Alliant Health Plans' credentialing is completed by the Credentialing Department. The Credentialing Representatives collect and verify information for each applicant, including education, licenses, practice history, historical sanctions, call coverage, hospital admitting privileges, and malpractice coverage.

Alliant Health Plans' Credentialing Department reserves the discretionary authority to deny or approve participation to applicants, except as otherwise required by law. Applicants applying for participation in Alliant Health Plans' network shall be responsible for and shall have the burden of demonstrating that all the requirements have been met.

The Credentials Committee meets each month, and the Board of Directors meets quarterly. Once a provider's application has been processed and reviewed by the committees, providers will be sent written notification of their effective date. Effective dates are not assigned retroactively, and are not determined by the application's submission date, signature date on contract, or a provider's initial start date at their practice.

A copy of the full credentialing criteria can be referenced in Appendix 1 or obtained by contacting Provider Relations at: 1-800-664-8480.

Credentialing Data Source

For all non-facility based providers, Alliant Health Plans' Credentialing Department utilizes the Council for Affordable Quality Health Care (CAQH), Universal Credential Data Source. To submit an application for network participation, simply complete the appropriate state application request provided by CAQH. Be sure to grant HealthOne Alliance the authorization to review all information.

Right to Review

To the extent permitted by law, Alliant Health Plans recognizes the provider's right to review submitted information in support of the credentialing application. Providers may obtain information regarding the status of their initial or re-credentialing application by contacting Provider Relations at: 1-800-664-8480 or providerrelations@alliantplans.com. This number can also be use to request information regarding general requirements for participation as well as correct any erroneous information.

Re-credentialing

Re-credentialing is conducted at least once every three (3) years in accordance with credentialing policy and procedures. Where required, before terminating a provider, a written notice of termination will be issued.

Provider Record Changes

It is imperative that provider records are kept current and accurate. This important and on-going administrative process impacts key business operations which include:

- Accurate and timely payments to providers
- Online Directory
- Reporting payments to the IRS
- Notification of policies and procedures

Any addition, change, or deletion to the information supplied on the original application/contract must be reported in writing. To ensure accuracy and allow for updates to be made in a timely manner, this written notification should be clear, concise, contain both the old and new information, and include the effective date of change. The following are the types of changes which should be reported as soon as possible:

- New Address
- New Telephone Number
- New Fax Number
- Additional office location
- Provider termination
- New ownership
- Change in provider name
- New Tax ID
- Change in hospital affiliation
- Change in board certification status
- Change in liability coverage
- Change in practice limitations
- Change in call coverage
- Change in licensure, state sanctions, and/or any restriction or malpractice awards

Please address all written change notices to Alliant Health Plans at the address below:

Alliant Health Plans
Attn: Provider Relations
1503 North Tibbs Road
Dalton, GA 30720

The Provider Update Form is conveniently located on our website www.alliantplans.com, and can be easily submitted via email. To submit updated information, click on Healthcare Providers, Provider Resources, and you will find the Provider Update Form under the General Resources section. From there, type your changes on the fillable form, save and email to Alliant Health Plans at providerrelations@alliantplans.com, or fax to 1-706-529-4275.

Administrative Guidelines

Claims Processing

This section of the manual explains how to file electronic and paper claims with Alliant Health Plans. Included are guidelines on how to file specific types of claims (for example, claims that require coordination of benefits), and identifies tools available to inquire about claim status.

Electronic claims filing is Alliant Health Plans' preferred claim submission process. Providers are encouraged to submit claims electronically by utilizing the third party clearinghouse listed in this section.

Alliant Health Plans accepts computer-generated paper claim submissions. Mail paper claims to:

Alliant Health Plans, Inc.
P.O. Box 3708
Corpus Christi, TX 78463

Electronic Claim Submissions

Electronic transmission or EDI (Electronic Data Interchange) is the most efficient, cost effective way to file claims. It can reduce administrative time, improve claim accuracy, and expedite claim payment turnaround time.

Providers interested in filing claims electronically should contact the clearinghouse listed below to set up this option or to verify their vendor of choice is able to interface with Change Healthcare.

Change Healthcare
Provider questions/problems: 1-800-845-6592 (option 2)
Connection inquiries: 1-800-444-4336
Payor ID: 58234

Electronic Claim Attachment

Alliant Health Plans cannot receive electronic claim attachments at this time. If claim submissions include an attachment (i.e. explanation of benefits, office notes, etc.), please mail a paper copy of the claim and attachment to:

Alliant Health Plans, Inc.
P.O. Box 3708
Corpus Christi, TX 78463

Claims Submission

When submitting an electronic or paper claim to Alliant Health Plans, be sure to complete all data elements necessary for the claim to be processed. In some situations, Alliant Health Plans must obtain additional information, which is not provided on the claim form (i.e. operative report).

A claim is not considered "clean" until Alliant Health Plans has all required information to determine a payment decision.

Original Claim

An original claim must be submitted within 365 days from the date the service was rendered, or as specified in your provider agreement. Claims received more than 365 days after the date of service (or the time frame specified in your provider agreement) may be denied for payment. The provider shall not bill the Member or Alliant Health Plans for any such denied claims.

Denied Claim

A claim denied due to insufficient information will be identified by a remark code on the EOP which will indicate the additional information required to process the claim. All claims, including resubmissions, must be submitted within 365 days of the initial date of service or the time frame specified in your provider agreement.

Adjusted Claim

If a previously processed claim needs to be resubmitted due to a billing error, or to provide additional information not originally included, please submit a paper claim to the address listed below. Please designate the corrected claim by stamping “Correction” or “Reconsideration” on the front of the claim form. Once Alliant Health Plans has re-evaluated the claim, a letter or new Explanation of Payment (EOP) will be issued.

Submit correction or reconsideration request to:

Alliant Health Plans, Inc.
P.O. Box 3708
Corpus Christi, TX 78463

Coordination of Benefits

When Alliant Health Plans is the secondary insurance carrier, please provide the primary carrier’s information along with a copy of the EOB in order for the claim to be considered for secondary payment.

Claim Status Verification Options

Participating providers may obtain claim activity information via: (a) online provider portal (b) automated telephone system, or (c) customer service representative.

Notification of Claim Determination

Alliant Health Plans provides notification when a claim is processed. An electronic notification is referred to as an Electronic Remittance Advice (ERA), and a paper notification is referred to as an Explanation of Payment (EOP).

When a claim determination results in the issuance of a payment to the provider, an ERA or EOP will be generated. Provider payments will be issued via electronic funds transfer (EFT) or may be mailed to the billing address recorded in Alliant Heatlh Plans' provider system. It is important to report address updates in a timely manner to ensure claim payments and correspondence are not delayed.

Each ERA or EOP will provide the following details:

- Provider name
- TIN
- Member name and ID number
- Group number
- Dates of service
- Applicable dollar amounts (for example: billed, non-covered, allowed)
- Member responsibility amounts (for example: deductible, coinsurance, copayment)
- Remarks

A Member's financial responsibility information will be detailed on the ERA or EOP. Dollar amounts will be reflected in the non-covered, deductible, and coinsurance fields, with a summary of these amounts reflected in the "Remarks" section of the EOP. Remarks indicate if a claim was processed as in-network or out-of-network, if benefit maximums have been met, and if additional information is required by Alliant Health Plans to continue processing a claim.

Electronic Payment

Alliant Health Plans encourages Electronic Funds Transfer (EFT). To enroll in EFT, submit the attached form to provider relations via email (providerrelations@alliantplans.com), or mail. Providers who enroll in EFT will receive their remittance advice through the Above Health web portal. Mail EFT enrollment forms to:

Alliant Health Plans
Attn: Provider Relations
1503 N. Tibbs Road
Dalton, GA 30720

Electronic Funds Transfer

What is EFT?

Electronic Funds Transfer (EFT) provides for electronic payments and collections.

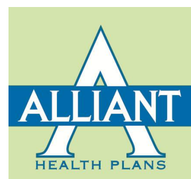
What is 835?

ANSI 835 is the American National Standards Institutes Health Care Claims Payment and Remittances Advice Format. This format outlines the first all electronic standard for health care claims. The format handles health care claims in a way that follows HIPAA regulations. HIPAA requires the use of 835 or an equivalent.

To Enroll in EFT:

1. Complete the enclosed enrollment form on a group/tax ID level. Please note the field clarifications below:
   - Provider Name = Legal Group Name
   - Provider Address Fields = Pay To Address Information
   - NPI = Group NPI
   - Provider Contact Name & Provider Email = Name and Email of person within practice who needs to receive payment notifications.
   - ➢ Attach a copy of a voided check (please note, the name on the check must match name on the form).
   - ➢ Note: All fields must be completed.
2. Return enrollment form and **copy of voided check** to Alliant Health Plans, Attn: Provider Relations, 1503 N. Tibbs Rd, Dalton, GA 30720 or email to your provider relations representative.
3. Your provider representative will return an Above Health Super User log in and User Guide to the contact listed on the enrollment form.

For additional information, please contact Alliant Health Plans Customer Service at 800-811-4793 or providerrelations@alliantplans.com.



Electronic Funds Transfer (EFT) Authorization Agreement

Provider Name	Doing Business As (DBA)
Provider Street Address	**Provider City**
Provider State/Province	**Provider ZIP Code/Postal Code**
Provider Tax Identifier (TIN) or Employer Identifier (EIN)	**National Provider Identifier (NPI)**
Provider Contact Name	**Provider E-Mail Address**
Provider Phone Number	**Provider Fax Number**
Financial Institution Name	**Financial Institution Street Address**
Financial Institution Telephone Number	**Financial Institution City/State/Zip**
Financial Institution Routing Number	**Type of Account at Financial Institution**
Provider's Account Number at Financial Institution	**Provider Preference for Grouping Claim Payments**
	____ TIN or ____ NPI (Please √ one)
Reason for Submission	
___ NEW ___ CHANGE ___ CANCEL (Please √ one)	

I (we) hereby authorize Alliant Health Plans to present credit entries into the bank account referenced above and the depository named above to credit the same to such account. I (we) understand that I am (we are) responsible for the validity of the information on this form. If Alliant Health Plans erroneously deposits funds into my (our) account, I (we) authorize Alliant Health Plans to initiate the necessary debit entries, not to exceed the total of the original amount credited for the current pay cycle.

I (we) agree to comply with all certification and credentialing requirements of Alliant Health Plans and the applicable program regulations, rules, handbooks, bulletins, standards, and guidelines published by Alliant Health Plans or its authorized affiliate(s) or subcontractor(s). I (we) will continue to maintain the confidentiality of records and other information relating to clients covered by programs offered through Alliant Health Plans in accordance with applicable state and federal laws, rules, and regulations.

____ ____

Authorizing Signature Date Signed

____ ____

Printed Name Title of Signatory

For the convenience of having direct deposit, you must be willing to download your EOB/EOP directly from the www.alliantplans.com website. *No paper copies will be mailed.

RETURN THIS FORM ELECTRONICALLY OR TO:

Alliant Health Plans
providerrelations@alliantplans.com
1503 North Tibbs Road, Dalton GA 30720
*Forms must be mailed-in or scanned and sent by e-mail. Fax copies WILL NOT be accepted due to readability.

Member Liability

- Members are responsible only for payment of non-covered services, copayments, deductibles, and coinsurance.
- Members are not financially responsible for the following:
  - Difference between the billed charge and the contracted amount
  - Charges denied due to re-coding of procedure or re-bundling of procedures
  - Any amounts denied due to the provider's failure to comply with the prior-authorization requirements of the Utilization Management program
  - Claims denied due to timely filing requirements
  - Medical and service errors
  - Non-medically necessary services
  - Other exclusions

Non-Medically Necessary Services

Neither Alliant Health Plans nor the Member is financially liable for non-medically necessary services.

In order to seek reimbursement from the Member for non-medically necessary services, the provider must obtain a signed waiver with the following information:

- Date of service
- Facility/provider name and place of service
- Service to be rendered
- Statement verifying the Member understands and agrees to the terms of the waiver
- Dated form with Member signature

The provider is responsible for maintaining a copy of the Member's waiver and providing to Alliant Health Plans upon request.

Claims Dispute Process

A claim reduction or denial is communicated through a statement printed on the Electronic Remittance Advice (ERA), Explanation of Payments (EOP), and/or letter.

Claim Pricing and Fee Schedule Disputes

Alliant Health Health Plans strives to make accurate and timely claim reimbursements. If there is a disagreement with claim pricing, please contact Customer Service to discuss any concerns.

Mail: Alliant Health Plans, Inc.
P.O. Box 3708
Corpus Christi, TX 78463

Phone: 1-800-811-4793

Notification of a reimbursement variance must be received by Alliant Health Plans within the time period specified in your Provider Agreement, but no more than 365 days from the payment date. The following key pieces of information are required in order for Alliant to address concerns:

- Provider name and tax identification number
- Provider location/address of service
- Member name and ID number
- Group number
- Date of service
- Description of issue

Internal Dispute Resolution

Contractual disputes can be resolved through the internal dispute resolution process. Please contact your local Provider Relations Representative, or Alliant Health Plans at:

Mail:	Alliant Health Plans Attn: Provider Relations 1503 North Tibbs Road Dalton, GA 30720
Phone:	1-800-664-8480
Fax:	706-529-4275
Email:	providerrelations@alliantplans.com

Alliant Health Plans will use all reasonable efforts to resolve your dispute within 60 days of receipt.

Policy Procedural Denials and Appeals

Claim denials based on the terms of the medical plan or policy may include, but are not limited to:

- Non-covered services
- Benefit discrepancies
- Eligibility
- Untimely filing
- Out of Network benefits

To file claims appeals, please submit a written request to:

Mail:	Alliant Health Plans, Inc. Appeals Department P.O. Box 3708 Corpus Christi, TX 78463
Fax:	1-866-634-8917

Providers are encouraged to submit claim appeals in writing. The written explanation should include the provider's position and supporting documentation in order to help expedite the review process.

A party independent from the original claim decision will be appointed to review and determine the outcome of the appeal.

Medical Appeals

Claim denials based on the terms of the medical or utilization management may include, but are not limited to:

- Failure to comply with utilization management requirements, including prior authorization
- Prior Authorization denied as not medically necessary
- Experimental or investigational services
- Exhaustion of benefit

To file claims or clinical appeals, please submit a written request to:

Mail: Alliant Health Plans, Inc.
Appeals Department
3910 S. IH-35, Suite 100
Austin, TX 78248
Fax: 1-866-370-5667

Providers are encouraged to submit claim appeals in writing. The written explanation should include the provider's position and supporting documentation in order to help expedite the review process.

A party independent from the original claim decision will be appointed to review and determine the outcome of the appeal. Appeals related to clinical matters will be reviewed by both Alliant Health Plans and an independent, external, board-certified, health care professional with related expertise. Alliant Health Plans may consult with, or request the involvement of medical experts, as part of the appeal process.

First-Level Appeal – Clinical and Non-Clinical

A provider or Member may initiate a first-level appeal on a claim. The appeal must be submitted within 180 days of the claim denial. First-level appeals submitted more than 180 days after the claim denial date will not be considered.

Pre-service Appeal	Decision made within 15 days from receipt of a request for appeal. Notification will be in written or electronic form.
Post-service Appeal	Decision made within 30 days from receipt of a request for appeal. Notification will be in written or electronic form.
Concurrent/Expedited Review	Decision made within 72 hours from receipt of a request for appeal. Notification will be in written or electronic form.

Second-Level Appeal

A provider or Member may initiate a second-level appeal on a claim. The appeal must be submitted within sixty (60) days from receipt of the first-level appeal decision.

Pre-service Claims	Decision made within 15 days from receipt of a request for review of the first-level appeal decision.
Post-service Claims	Decision made within 30 days from receipt of a request for review of the first-level appeal decision. Notification will be in written or electronic form.
Concurrent/Expedited Review	Decision made within 72 hours from receipt of a request for review of the first-level appeal decisions. Notification will be in written or electronic form.

Urgent Appeals

Appeals may require immediate action if a delay in treatment could pose a health risk to the Member. In urgent situations, the appeal does not need to be submitted in writing. Please contact Customer Service at: 1-800-811-4793.

Claim Underpayments

If there is concern that an underpayment may have occurred, please submit a written request for an adjustment within 365 days from the date of payment, or ERA/EOP. Requests for adjustment submitted after the time frame may be denied for payment. Additionally, the provider is not permitted to bill the Member, or Alliant Health Plans, for underpayment amount. Please submit a written request for adjustment to:

Mail: Alliant Health Plans, Inc.
Appeals Department
P.O. Box 3708
Corpus Christi, TX 78463

Fax: 1-866-634-8917

Claim Overpayments

Alliant Health Plans will request an overpayment refund from the provider within 365 days from the claim payment date, or as mandated by Georgia state law. Alliant will send the provider one formal refund request indicating the refund must be issued within 30 days from the date of the letter. If the provider does not issue the refund within 30 days, Alliant will begin recouping the funds 60 days from the date of the refund request. In order to dispute refund requests, providers must contact Alliant within 60 days of refund request receipt.

Coverage Guidelines

This section outlines the general guidelines Alliant Health Plans uses to consider reimbursement of procedures and services. Please note, this is not an exhaustive list. If the reimbursement guideline is not identified in your provider agreement, or in this section, please contact Customer Service for additional information at: 1-800-811-4793.

Reimbursement for Covered Services

Payment for covered services is solely the responsibility of the payor, and shall be the lessor of the participating provider's billed charges, or the reimbursement amount provided in the participation agreement, minus applicable copayments, deductibles, and coinsurance. The rates in the participation agreement will be payment in full for all services furnished to Members. Undisputed amounts, due and owing for clean claims for covered services, will be payable within the timeframe required by Georgia state law. If the payor fails to pay a clean claim within the timeframe required by Georgia state law, prompt pay penalties shall be due and payable by such payor with respect to such claim to the extent required under applicable law.

Add-On Procedures

Add-on procedures are performed in addition to the primary procedure, by the same physician, and cannot be billed as a stand-alone procedure. Add-on procedures must be billed on the same claim as the primary procedure and are reimbursed at 100% of the applicable fee.

ASC Groupers

Alliant Health Plans uses ASC Groupers to define out-patient reimbursement. ASC Groupers are periodically updated. For a complete current list of ASC Groupers, please contact Provider Relations at 1-800-664-8480 or email providerrelations@alliantplans.com.

Coordination of Benefits

Coordination of Benefits (COB) is the procedure used to pay health expenses in the event a person is covered by more than one insurance plan. Alliant Health Plans follows the regulations established by Georgia state law in order to determine which insurance plan is the primary payor, and the amount owed by the secondary payor. With regard to covered services rendered to a Member, the provider agrees to cooperate in the secure exchange of information between payors to coordinate benefits and third party liabilities.

Assistant Surgeon Services

Alliant Health Plans uses CMS guidelines to determine if an assistant surgeon's charges are allowed for the billed procedure.

Facility Reimbursement Rates

If a Member is confined to an in-patient facility at the time a rate adjustment becomes effective, or at the time of a policy/plan change on the part of the Member, the facility reimbursement for covered services during the in-patient stay will be based on the rates in effect at the time the Member was admitted to the facility. If an individual ceases to be a Member while being confined to an in-patient facility, Alliant Health Plans will reimburse the facility for covered services in a pro-rated manner. The pro-rated reimbursement will be based on the total number of days, during the duration of the stay, that the individual was a Member.

Claim Edits

Provider claims are processed through editing software to ensure consistency in claims processing and payment standards. Edit logic is based on generally recognized and authoritative coding resources, which include, but are not limited to, Ingenix and Code-it-Right software systems.

Modifier Guidelines

When appropriate, providers should use modifiers to further define or explain a service. Alliant Health Plans reimburses modifiers as outlined below:

Modifier	Description	Definition	Payment
24	Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Post-operative Period	The physician or other qualified health care professional may need to indicate that an evaluation and management service was performed during a post-operative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding modifier 24 to the appropriate level of E/M service.	100% of allowable, if appropriate

25	Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service	It may be necessary to indicate that, on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual pre-operative and post-operative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported. The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service.	100% of allowable, if appropriate
50	Bilateral Procedure	Unless otherwise identified in the listings, bilateral procedures that are performed at the same session should be identified by adding modifier 50 to the appropriate CPT code. **Note:** Modifier 50 must only be applied to the services and/or procedures on identical anatomic sites, aspects or organs. Modifier 50 cannot be used when the code description indicates unilateral or bilateral.	150% of allowable (100% of the first line and 50% of second.)
51	Multiple Procedures	When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services, or provision of supplies (eg, vaccines), are performed at the same session by the same individual, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). **Note:** This modifier should not be appended to designated "add-on" codes.	150% of allowable (100% of the first line and 50% of second.) Reimburse-ment is based on highest RVU weight.

52	Reduced Services	Under certain circumstances, a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. Under these circumstances, the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service.	50% of allowable
53	Discontinued Procedure	Under certain circumstances, the physician or other qualified health care professional may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances, or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the individual for the discontinued procedure. **Note:** This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction, and/or surgical preparation in the operating suite.	25% of allowable
54	Surgical Care Only	When one physician, or other qualified health care professional, performs a surgical procedure, and another provides pre-operative and/or post-operative management, surgical services may be identified by adding modifier 54 to the usual procedure number.	70% of allowable
55	Post-operative Management Only	When one physician, or other qualified health care professional, performed the post-operative management and another performed the surgical procedure, the post-operative component may be identified by adding modifier 55 to the usual procedure number.	20% of allowable

56	Pre-operative Management Only	When one physician, or other qualified health care professional, performed the pre-operative care and evaluation and another performed the surgical procedure, the pre-operative component may be identified by adding modifier 56 to the usual procedure number.	10% of allowable
57	Decision for Surgery	An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding modifier 57 to the appropriate level of E/M service.	100% of allowable
58	Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Post-operative Period	It may be necessary to indicate that the performance of a procedure or service during the post-operative period was: (a) planned or anticipated (staged), (b) more extensive than the original procedure, or (c) for therapy following a surgical procedure. This circumstance may be reported by adding modifier 58 to the staged or related procedure.	70% of allowable
59	Distinct Procedural Service	Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59	100% of allowable if appropriate

		be used. **Note:** Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.	
62	Two Surgeons	When two surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If additional procedure(s), including add-on procedure(s), are performed during the same surgical session, separate code(s) may also be reported with modifier 62 added. **Note:** During the same surgical session, if a co-surgeon acts as an assistant in the performance of an additional procedure(s) other than those reported with the 62 modifier, those services may be reported using separate procedure code(s) with modifier 80 or 82 added as appropriate.	62.5% of allowable
76	Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional	It may be necessary to indicate that a procedure or service was repeated by the same physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure or service. **Note:** This modifier should not be appended to an E/M service.	70% of allowable

77	Repeat Procedure by Another Physician or Other Qualified Health Care Professional	It may be necessary to indicate that a basic procedure or service was repeated by another physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 77 to the repeated procedure or service. **Note:** This modifier should not be appended to an E/M service.	70% of allowable
78	Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Post-operative Period	It may be necessary to indicate that another procedure was performed during the post-operative period of the initial procedure (unplanned procedure following initial procedure). When this procedure is related to the first, and requires the use of an operating/procedure room, it may be reported by adding modifier 78 to the related procedure. (For repeat procedures, see modifier 76.)	70% of allowable
79	Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Post-operative Period	The individual may need to indicate that the performance of a procedure or service during the post-operative period was unrelated to the original procedure. This circumstance may be reported by using modifier 79. (For repeat procedures on the same day, see modifier 76.)	70% of allowable
80	Assistant Surgeon	Surgical assistant services may be identified by adding modifier 80 to the usual procedure number(s).	16% of allowable
81	Minimum Assistant Surgeon	Minimum surgical assistant services are identified by adding modifier 81 to the usual procedure number.	10% of allowable
82	Assistant Surgeon (when qualified resident surgeon not available)	The unavailability of a qualified resident surgeon is a prerequisite for use of modifier 82 appended to the usual procedure code number(s).	20% of allowable
AS	Physician assistant, Nurse Practitioner, or Clinical Nurse specialist services for assistant at surgery	Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery services may be identified by adding modifier AS to the usual procedure number(s).	16% of allowable

Alliant Health Plans has relied on information publicized by the American Medical Association in the presentation of usage of CPT modifiers. The information contained therein should not be used in lieu of the Members specific plan language, but used as a tool to understand the acceptance and reimbursement of CPT modifiers for an Alliant Health Plans Member.

Modifiers will price at the noted precentage of allowable, unless a reimbursement agreement has been made by the provider and Alliant Health Plans. If a pre-set reimbursement agreement has been made, the modifier will be priced according to the terms outlined in the agreement.

Clinical information documented in the patient's records must support the use of submitted modifier(s). Medical records are not required with the claim, but must be made available upon request.

Multiple Procedures

Unless otherwise stated in the provider agreement, Alliant Health Plans utilizes CMS guidelines related to multiple surgeries.

Utilization Management

Many of Alliant's plans and policies are subject to utilization management requirements. This section will provide a general overview of the utilization requirements and the provider's responsibilities.

Prior Authorization of Services

Providers must comply with prior authorization requirements. Services which require prior authorization can be found at www.alliantplans.com. Facilities and/or ordering providers are responsible for obtaining all necessary prior authorization requirements. The Member may initiate prior authorization by calling Customer Service. However, clinical information must be provided by facilities and/or providers. Utilization management decision-making is based on the appropriateness of care and services, and the existence of coverage at the time the care was rendered.

Alliant Health Plans does not reward providers or other individuals for issuing denials of coverage, service, or care. Utilization Management decision making is based only on the appropriateness of care and services, and the existence of coverage at the time the care was rendered. Financial incentives for Utilization Management decision makers do not encourage decisions that result in underutilization.

Prior Authorization Request Options

Hours of Operation	8:30 am to 5:00 pm (EST) On-call 24 hours per day/7 days per week
Phone	1-800-865-5922
Fax using Provider Prior Authorization Form	1-866-370-5667 which can be found at www.alliantplans.com Click Healthcare Professionals Choose Provider Resources Choose Prior Authorization Request Form under Medical Resources
Online Tool (self registration)	Please refer to Provider Web Resources in the Provider Manual for more information

Prior authorization must be obtained for all elective services in advance of the services being rendered. ***Requests received on the date of admission or date of service will not be accepted.***

Prior Authorization Review Process

The procedures for the appeal process are described in the manual under Claims Processing Guidelines.

Medical Necessity Determinations

The clinical criteria used in making medical necessity determinations will be provided upon written request. Please send requests to:

Alliant Health Plans, Inc.
3910 S. IH-35, Ste 100
Austin, TX 78248

For all urgent or emergent inpatient admissions, notification of admission must be provided to Alliant Health Plans Utilization Department **within 24 hours of admission or first business day.**

Denial of authorization may be appealed in writing, or discussed with a reviewer through the appeals process which is described in the provider manual.

Quality Management

Alliant Health Plans' mission is to provide high-quality health care at an affordable price. Alliant strives to be stewards of the communities we serve by focusing on improving the health care options available to Members, participating in local and state-wide health improvement initiatives, and by participating in both community and health plan outreach efforts.

Primary goals of the Alliant Health Plans Quality Management Program:

- Continuously meet Alliant's mission, regulatory and accreditation requirements
- Ensure the delivery of high-quality, appropriate, efficient, timely, and cost-effective health care and services
- Improve Member's overall quality of life through the continuous enhancement of Alliant's health management programs
- Enhance quality improvement collaboration with all levels of care to include, but not limited to: Primary Care, Ob/Gyn and Behavioral Health
- Ensure a safe continuum of care through continuity and coordination of care initiative
- Improve health promotion/disease prevention messages and programs for Members through Member and provider website, and quarterly provider newsletters
- Review performance against clinical practice guidelines
- Address improvements in Member satisfaction through collaboration with network providers and meetings with Members
- Continue to address improvements in provider satisfaction via on-site and at-large meetings with providers
- Promote community wellness programs and partner with community services and agencies, such as the North Georgia Health Care Partnership
- Promote and facilitate the use of quality improvement techniques and tools to support organization effectiveness and decision-making
- Ensure culturally competent care deliver through the provision of information, training, and tools to staff/providers in order to support culturally competent communication

Annual Evaluation

Alliant Health Plans conducts an annual evaluation of the Quality Management Program in order to ensure quality improvement and future programming. In 2013, Alliant Health Plans developed program documents and policies and procedures, identified clinical and service indicators, and redesigned the committee structure to better serve Members and providers. Alliant Health Plans received NCQA Interim Accreditation for the Exchange products and began preparing for NCQA First Accreditation, which occurred in early 2015. Alliant Health Plans achieved Accreditation.

Disease Management

Alliant Health Plans offers four disease management programs to for our Members. These programs are based on clinically accepted and approved practice parameters and are endorsed by nationally recognized medical associations or entities. The program guidelines are reviewed at least every two years by Alliant.

For the management of Attention-Deficit/Hyperactivity Disorder (ADHD) , Alliant adopted the 2011 American Academy of Pediatrics Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder (ADHD) in Children and Adolescents as our clinical guidelines (http://pediatrics.aappublications.org/content/early/2011/10/14/peds.2011-2654).

For the management of asthma, Alliant adopted the 2007 National Asthma Education and Prevention Program Expert Panel Report 3 Guidelines for the Diagnosis and Management of Asthma as our clinical guidelines (www.nhlbi.nih.gov/guidelines/asthma/asthgdln.htm).

For the management of depression, Alliant adopted the American Psychiatric Association Practice Guideline for the Treatment of Patients with Major Depressive Disorder, Third Edition as our clinical guidelines
(http://psychiatryonline.org/content.aspx?bookid=28§ionid=1667485).

For the management of Diabetes, Alliant adopted the 2015 Standards of Medical Care in Diabetes as published by the American Diabetes Association as our clinical guidelines
(http://care.diabetesjournals.org/content/38/Supplement_1.toc)

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(http://care.diabetesjournals.org/content/38/Supplement_1.toc).

Please contact Alliant Customer Service if you would like a copy of the guidelines and are unable to access online.

The disease management programs are designed to educate diagnosed Members and provide assistance in management of these conditions. Alliant's goal is to encourage Members to achieve and maintain optimal health. Identified members are automatically enrolled in Alliant's disease management programs. Condition-specific care plans for moderate and high-risk individuals are sent to Members following completion of assessments. All program Members are mailed educational materials. Members with higher risk levels receive outreach calls and telephonic case management. Providers may refer Members to disease management programs by contacting the Medical Management Department at: 1-800-865-5922.

Preventative Health

Alliant Health Plans has also established preventive health guidelines to improve health care quality, reduce unnecessary variation in care, assist providers in guiding and educating patients, provide a basis for wellness programs, and improve Members' health. These guidelines will help guide wellness interventions, educate providers, and encourage self-management lifestyle changes for Members.

For the management of adult health needs, Alliant adopted the United States Preventive Services Task Force (USPSTF) A and B recommendations and the Centers for Disease Control (CDC) recommendations for the following categories:

Pregnancy Women
Children 0-24 months
Children 2-19 years
Adults 20-64 years
Adults 65 years and older

Case Management

Alliant Health Plans' case management program is designed to assist Members in transitions of care, coordination of care, acute/episodic needs, and complex care management. This program includes telephonic case management, comprehensive assessment tools, and the development of individualized, prioritized care plans. Members are identified for this program via data analysis, predictive modeling, and referrals from utilization management, other disease/wellness programs, providers, and self-referrals. To refer a Member into the case management program, please contact the Medical Management Department at: 1-800-865-5922.

Pharmacy Benefit Program

Navitus

Navitus Health Solutions is a full-service pharmacy benefit company committed to lowering drug costs, improving health, and providing superior customer service in a manner that instills trust and confidence.

Navitus takes great pride in achieving a perfect score on the 2013 Pharmacy Benefit Management Institute (PBMI) customer satisfaction report, which reflects our people-first commitment.

Since its inception in 2003, Navitus has challenged the status quo. Robert Palmer, Navitus' founder, believed that the current state of the PBM industry could no longer stand as the benchmark for decision-makers to select their PBM providers; and the business model must challenge the status quo to ensure complete alignment of interests between the PBM and its clients. True to these beliefs, Navitus' independent and full disclosure business model ensures complete alignment of its interests with those of its clients and their members by:

- Putting people first with its stewardship-driven model
- Delivering clinically appropriate, lowest-net-cost therapies and the highest quality standards of care, consistent with its URAC PBM accreditation
- Basing true value on *lowest-net PMPM drug cost*
- Considering all network discounts and rebates the *contract floor*—not the contract ceiling
- Providing full pass-through of all network rate and manufacturer rebate upside performance and negotiated pricing improvements *immediately* over the contract life
- Engaging members to drive adherence and improved health
- Providing unsurpassed reporting and business support
- Providing advanced technology to meet all regulatory requirements and to support data integration and health information exchanges for coordination across provider networks
- Supporting client-specific pricing strategies, such as 340B and GPO pricing

The business model and government preparedness activities enable Navitus to assist it's clients in navigating the complexities of health care reform. Navitus is already well-positioned to address the Patient Protection and Affordable Care Act (PPACA), as demonstrated by its full pass-through pricing; full transparency and full disclosure operations; clinically-appropriate, lowest-net-cost therapies; and consumer engagement, prevention and adherence with interventions and targeted solutions that encourage optimal behavior.

Diplomat Specialty Pharmacy

Alliant Health Plans' vendor for specialty pharmacy medications is Diplomat Specialty Pharmacy. Diplomat is the nation's largest, privately-owned, independent specialty pharmacy. Diplomat offers medication management programs and services to patients with serious and chronic conditions. Diplomat provides specialty pharmacy services for those medications that may require additional support for patients to experience the outcomes expected by both the patient and their prescriber. Diplomat's patient care coordinators and pharmacists are available to help patients manage any side-

effects they may experience, connect patients with support groups when needed, coordinate delivery each month at the time and location most convenient for the patient, and be a resource for everything needed pertaining to the patient's specialty therapies.

Diplomat's website (http://diplomat.is) provides patients, prescribers and clients access to information detailing their services. Members can view Diplomat's wellness services, specialty patient services, calendar of events, educational services, contact information and visit Diplomat's blog. Patients are able to sign up online for specialty patient programs and seminars, make inquiries, and access disease specific links and resources. The Diplomat team can be reached toll free at: 1-877-977-9118.

PHR Anywhere℠

To facilitate the patient/physician relationship, and to optimize the quality of care for Members, Alliant Health Plans has made it possible for patients to save their personal health record (PHR). A Personal Health Record (PHR) is a tool which enables individuals to play a more active role in managing his/her health care. Whether a Member is active and healthy, managing a chronic condition, or caring for children or an elderly loved one, PHRAnywhere℠ is the solution for managing all health related information. Members are empowered to share their comprehensive health care record with their provider granting them access to important information to assist in making safe, effective decisions.

Some of the many features of PHRAnywhere℠ include:

- Tracking medications and recently filled prescriptions
- Accessing insurance plan information, including prescription drug benefits
- Logging and updating family medical treatment history
- Storing important health care documents, such as Living Wills and DNR Orders
- Viewing recent office visit history
- Providing physician contact information

How to Access PHR Anywhere℠

1) Log onto www.alliantplans.com
2) Click on Member Portal to be directed to PHRAnywhere℠
3) Enter user ID and password under Provider Log In. Check the box to agree with the Usage Agreement and click Sign In. If a login is needed, please click on Provider Registration to request a login.
4) Use the PHR Anywhere℠ Member Search. The My Patients' Search is to be used when a Member has previously granted access to their medical information
    a. Enter the PHR Anywhere Card # (on back of PHR Anywhere card)
    b. Subscriber ID # (on Alliant Health Plans Member ID card)
    c. Date of birth
    d. Zip code
    e. Physician key (This is the 4-digit key which the Member received in their PHR Anywhere packet that came with their card). Initially, the physician key is the 2-digit month, and the 2-digit day of the Member's birthday, unless the key has been changed by the Member.
    f. If a Member needs to reset their physician key, the Member will need to call: 1-866-262-3881.
    g. Click the box acknowledging you are a treating provider and hit search
5) Member's name should appear in a box. Click on View, which is located to the left of the name in order to access the Member's health information
6) Options are indicated on the left of the screen (Demographics, Insurance Verification, Health Summary, Visit History, Exam Forms, Documents, and Reference). Click on the icon to access information.

Member Rights & Responsibilities

Members' Bill of Rights

Alliant Health Plans Members have distinct rights and responsibilities. A Member is entitled to receive service, care, and confidentiality. Along with these rights come certain responsibilities. Please find a reference list of Member rights and responsibilities below.

1. Available and accessible service that can be promptly secured as appropriate for the symptoms presented, in a manner that assures continuity. When medically necessary, the right to emergency services available 24 hours a day, 7 days a week.
2. Receive information regarding health problems, treatment alternatives, and associated risks sufficient to assure an informed choice.
3. Privacy of medical and financial records that will be maintained by Alliant Health Plans, or a participating provider, in accordance with Georgia state law.
4. File a complaint and/or grievance according to the procedure as set forth in the appropriate benefit plan documents if a problem is experience with Alliant Health Plans, or a participating provider.
5. Be treated privately, with respect and dignity.
6. Participate in decisions regarding personal health care.
7. Access medical records in accordance with Georgia state law.
8. Be provided with information about the managed care organization, its services, the providers rendering care, and members' rights and responsibilities.
9. Have a family member or designated person facilitate care when a Member is unable to care for him or herself.

Members' Responsibilities

1. Read the benefit plan documents* and Member materials in their entirety and comply with the rules and limitations as stated.
2. Contact the participating providers to arrange for medical appointments as necessary.
3. Notify participating providers in a timely manner of any cancellation of an appointment.
4. Pay deductibles, co-payments, or co-insurance as stated in the summary of benefits at the time service is provided.
5. Coordinate or receive pre-authorization or pre-certification for services when required, and comply with the limits of the authorization.
6. Carry and use the Alliant identification card, and identify as an Alliant Health Plans Member prior to receiving medical services.
7. Use participating providers consistent with the applicable benefit plan.
8. Use participating providers for services that do not require written pre-authorization.
9. Provide, to the extent possible, information needed by professional staff in caring for the Member.
10. Follow instructions and guidelines given by those providing health care services.

*Benefit Plan Documents include the Group Evidence of Coverage, Summary of Benefits and any applicable Rider(s).

HIPAA

Alliant Health Plans, Inc. is committed to the protection of personally identifiable health information of our Members by complying with the HIPAA Standards for Privacy of Individually Identifiable Health Information (the "Privacy Rule"), the HIPAA Standard Transactions and Code Sets Regulations, and the HIPAA Security Standards Regulations (the “Security Rule”). *See* 45 C.F.R Parts 160, 162 and 164, and the Health Information Technology for Economic and Clinical Health Act, which is at Section 13400, *et. seq.* of the American Recovery and Reinvestment Act of 2009 (“ARRA”), 42 U.S.C. § 17921, *et. seq.*, and guidance and/or regulations promulgated thereunder (“HITECH”), and require that network providers comply with these standards and regulations. All network providers are expected to implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the personal health information (PHI), either electronic or otherwise, that they create, receive, maintain or transmit, on behalf of the plan(s) in which they participate as required by the Security Rule.

Secure Emails

To comply with HIPAA regulations, Alliant Health Plans sends ALL emails containing personal health information (PHI) in a secure format via our Tumbleweed Secure Email System. PHI includes identifiable information such as member name, birth date, social security number, subscriber number, diagnosis or other member specific information. To access the Tumbleweed Secure Email you will need to set up a username and password. If you have any trouble creating a login/password, or have forgotten your password, please contact Alliant Health Plans Provider Relations at: 1-800-664-8480 or providerrelations@alliantplans.com.

Please ensure that any email you send which includes PHI is sent via a secure email system. If you do not have access to a secure email system, HIPAA regulations allow for information to be sent via a secure fax. This fax can be sent directly to Alliant Health Plans for review. For further direction on what components are considered protected information under the Health Insurance Portability and Accountability Act, please visit www.hhs.gov/hipaa.

Provider Manual
Appendix 1: Credentialing Criteria

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Appendix 1: Credentialing Criteria

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Revised: April 2016

Health One
Initial and Recredentialing Criteria

APRNs

In order to be considered as a Participating Practitioner, Practitioner must establish compliance with the following qualification requirements and responsibilities, as required by Health One and Health One's Credentials Committee: Failure to comply with or satisfy the Health One Network qualification criteria outlined below may result in the Practitioner's voluntary relinquishment, withdrawal or termination from participation in the Health One Network.

APRNs will be required to follow the Guidelines of the state of Georgia and/or any other state in which they actively practice. Requirements for APRNs shall comply with the following eligibility requirements which shall require reporting and monitoring by the Supervising/Delegating Physician and certifications of compliance with the applicable standards to the Health One Network as set forth herein.

SUPERVISING/DELEGATING PHYSICIAN

1. In accordance with the applicable laws for the APRN's scope of practice, the Supervising/Delegating physician must be in a comparable specialty area or field as that of the APRN and the APRN and Physician shall provide certification to Health One that both parties practice in comparable specialties. APRN shall produce a copy of his or her certification in the specialty area or field of his or her specialty. The Supervising/Delegating Physician shall be licensed in the State of Georgia or any other State in which they actively practice and shall have an office in the corresponding state. The Supervising/Delegating Physician must be a participating member of the Health One Network. The APRN shall not employ the Supervising/Delegating Physician to avoid any conflict of interests.

2. APRN shall identify the alternative Supervising/Delegating Physicians that will provide coverage and supervision for the APRN in the event the primary Supervising/Delegating physician is not available, including verification of the licenses and proof of participation in the Health One Network.

3. The APRN shall produce a valid copy of a Nurse Protocol Agreement between a Supervising/Delegating Physician and an APRN. Supervising/Delegating Physician must confirm to Health One that he or she shall be immediately available for consultation with the APRN. APRN shall file the Nurse Protocol Agreement with Health One at the time of credentialing and recredentialing. The Nurse Protocol Agreement shall be readily available for review and on site at all times. APRN shall be responsible to produce a copy of the Protocols, and if the Protocols are contained within a book, the name of the book, author and edition year shall be provided. In the event of a change in the Protocols, APRN shall provide the modified Protocols or identification of the books within ten (10) days upon change of the Protocol. For APRNs that write prescriptions, the Nurse Protocol Agreement must address the limitations on the scope of practice and shall conform with the limitations set forth by the applicable laws.

4. APRN and Supervising/Delegating Physician shall provide and identify the TIN which shall be utilized by the APRN and the Supervising/Delegating Physician as a participating member of the

Network for payment remittance purposes. The TIN shall be used to identify the APRN and the Supervising/Delegating. The APRN shall also provide the site of service address affiliated with such TIN. If the participating physician ceases to participate in the Network, APRN shall have thirty (30) days, commencing on the date that the supervising-participating physician ceases to participate in the Network, to notify Network in writing of the alternative participating physician and the related TIN that shall be used by the APRN to remain a participating provider in the Network. If the APRN fails to provide written notice of the alternative supervising -participating physician as well as the related TIN within the thirty (30) day notice period, APRN participation in the network shall cease and be deemed voluntarily relinquished upon the expiration of the thirty (30) days.

EDUCATION

5. The education requirements for a Participating Practitioner are as follows:

   5.1 Practitioner shall present official documentation indicating he/she has graduated with a master's degree or doctorate in Nursing from an accredited professional school and provide complete information with respect to professional training/activities which shall include, without limitation, the following:

   - Undergraduate Education
   - Medical and/or Professional Education
   - Licensed Professional References
   - Work History

   Health One has the sole discretion with respect to the determination of the acceptability of such credentials.

LICENSE

6. Practitioner is a person with a current, valid medical license that is not suspended, lapsed, expired or voluntarily surrendered in the State of Georgia and/or any other state in which they actively practice.

DEA

7. Practitioner must hold a current, valid and unrestricted Drug Enforcement Agency (DEA) registration, as appropriate in the State of Georgia and/or any other state in which they actively practice, or provide evidence satisfactory to Health One that the Practitioner does not require such registration in order to deliver appropriate care.

   7.1 If applicable, the APRN and Delegating Physician shall certify in writing that the prescriptions or ordering of drugs conforms with the legal requirements related to prescriptions, forms and transmission of orders for prescriptions upon credentialing and re-credentialing.

8. Controlled Substances. APRN shall ensure that all patients that receive a prescription drug order for any controlled substance pursuant to a nurse protocol agreement shall be personally

evaluated or examined by the delegating physician or other alternative delegating physician designated by the delegating physician on at least a quarterly basis. On a quarterly basis, the Delegating Physician shall certify compliance with these requirements. Upon network's request to review, this written report shall be submitted to Health One.

9. Onsite-Review. As applicable and as required by law for APRNs that write prescriptions, the delegating physician shall document and maintain a record of onsite observation on a quarterly basis to monitor quality of care being provided to the patients. Upon network's request to review, this written report shall be submitted to Health One.

INSURANCE

10. Practitioner shall purchase and maintain, at the sole cost and expense of Practitioner, policies of professional liability in amounts required by Health One. The current minimum amounts set forth by Health One are ONE MILLION DOLLARS ($1,000,000) per occurrence/THREE MILLION DOLLARS ($3,000,000) aggregate. Practitioner shall authorize the carrier to issue to Health One certificate of insurance policies of Practitioner upon request of Health One. Notwithstanding the foregoing, Practitioner shall provide Health One with notification within three (3) days of any cancellation, termination or material alteration of any such insurance policies. Prior to the expiration or cancellation of any such coverage Practitioner shall secure replacement of such insurance coverage upon the same terms, and shall furnish Health One with a certificate of endorsement as described herein. Evidence of the effective policy reflecting such insurance shall be provided with the application.

MALPRACTICE

10.1 Details of any professional liability actions that have resulted in adverse judgments or any financial settlements.

10.2 Details of any pending professional liability actions.

This information shall be reviewed by Health One. The evaluation shall consider the frequency of such actions, the financial impact of such actions, and the clinical circumstances surrounding the alleged acts of malpractice. Practitioners shall not be automatically disqualified from participation in Health One due to a history of judgments and/or settlements. Each case will be evaluated based on its merits. Health One has sole discretion in the determination of the impact of this information for the purposes of credentialing.

ADMITTING PRIVILEGES

11. *APRN's Supervising/Delegating Physician* has current and unrestricted admitting privileges, at a participating hospital accredited by a Health One approved Accrediting body; or written evidence that the applicant does not require hospital admitting privileges in order to deliver satisfactory professional services. *Supervising/Delegating Physician's* that do not have hospital admitting privileges can submit a Health One Hospital Attestation Form or approved letter which identifies a participating hospitalist, or Practitioner, who practices in the same, or similar,

specialty and has agreed to admit Practitioner's patients on Practitioner's behalf. It is within Health One's sole discretion to approve or disapprove these requests based on its assessment in light of patient needs and quality and risk management standards.

11.1 Supervising/Delegating Physician shall confirm whether his or her application for clinical privileges or medical staff membership, including a change in staff category at any hospital or healthcare facility has ever been reduced, limited, suspended, terminated or have been placed on probation or restriction or whether he or she has ever resigned to avoid disciplinary action, or investigation or whether any related actions or investigations are pending. Practitioner shall submit any applicable information regarding the same for review and consideration.

PEER REFERENCES

12. Practitioner shall provide the name, address, phone, fax and email address of three professional peers who can provide reliable information based on significant personal experience as to clinical ability, ethical character and ability to work with others.

CALL COVERAGE

13. In order to assure continuous and quality care to patients, Participating Practitioner in the Health One Network shall provide coverage consistent with the guidelines set forth below for times when they are absent from their medical practice. Notwithstanding the below, it is in Health One's sole and absolute discretion, based on its assessment of the coverage proposal considering patient needs and quality and risk management standards, to approve or disapprove such alternative coverage requests.

13.1 Practitioner must have made arrangements to allow patients and other practitioners to contact Practitioner (or covering provider) 24 hours a day, 7 days a week. Automatic referrals to the emergency department shall not satisfy the call coverage obligations of a Participating Practitioner.

13.2 To ensure continuity of patient care, Practitioner must have made arrangements with Supervising/Delegating Physician to provide call coverage on a 24 hours a day, and 7 days a week basis to respond to all calls in a prompt manner.

13.3 Call Coverage must be provided by a Supervising/Deletating Physician who (i) practices in the same or similar specialty as deemed reasonable by Health One and (ii) is capable of providing services of an urgent or emergency nature which the Practitioner being covered would typically provide for patients in his/her practice. The covering Practitioner is to be a Supervising/Delegating Physician that is a Participating Practitioner with Health One.

13.4 If a Practitioner cannot secure coverage from a Participating Practitioner in the same or similar specialty and the Practitioner practices in a Rural Area, as defined herein, the Practitioner must submit a request in writing to Health One for coverage by another Practitioner who can provide the appropriate level of services to cover for the requesting

Practitioner or for a hardship waiver of the coverage requirements. *Rural Area* means an area that is not an Urban Area as defined A Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA), as defined by the Executive Office of Management and Budget, excluding Whitfield and Murray Counties, Georgia. Health One will consider all such exception requests in a timely manner. In addition, depending upon the patient needs to access healthcare services in the Rural Area, Health One may grant an exception to ensure access to healthcare services for the beneficiaries that receive care from HealthOne Participating Practitioner.

13.5 Failure by a Practitioner to comply strictly with this policy will result in a written warning being issued to the offending Practitioner by Health One wherein the Participating Practitioner shall have ten (10) days to provide a written plan to cure the deficiency. If Practitioner fails to cure the deficiency within thirty (30) days or a time period that is deemed reasonable by Health One, upon submission of the written plan to cure the deficiency, Practitioner shall fail to maintain qualifications to be eligible as a Participating Practitioner and such participation shall automatically terminate and be deemed voluntarily withdrawn.

13.6 Decisions on Practitioner participation with the Health One Network or termination of a Participation Agreement based on this Call Coverage Policy involve the business objectives of Health One and not matters of professional competence. Failure to obtain and maintain call coverage will be deemed a voluntary withdrawal from the Health One Network for failure to satisfy the qualification criteria, and therefore, no rights of appeal or national databank reports will be applicable to such decisions.

DISCLOSURE

14. Practitioner shall confirm the following information and provide the necessary documentation and information to enable the Credentials Committee to fully evaluate the Provider's qualifications to participate in the HealthOne Network:

14.1 Practitioner shall confirm whether he or she has been the subject of an investigation or Adverse Action and provide any applicable documentation regarding same. "Adverse Action" means a voluntary or involuntary termination, loss of, reduction, withdrawal, limitation, restriction, suspension, revocation, denial or non-renewal of membership, clinical privileges, academic affiliation or appointment, or employment, including any adverse action regarding professional licensure registration, certification, any previously successful or currently pending challenges to such licensure registration or certification.

14.2 Practitioner shall confirm whether he or she has been the subject of any report to a state or federal data bank, state licensing or disciplining entity and provide any applicable documentation regarding same.

14.3 Practitioner shall confirm whether he or she has ever been suspended, debarred, fined, disciplined, sanctioned or otherwise restricted or excluded from participating in the Medicare or Medicaid program, or any federal, state or private health insurance program.

14.4 Practitioner has not been convicted of a felony or been convicted of Medicare, Medicaid or other governmental or private third party payor fraud or program abuse or have been required to pay civil penalties for the same.

14.5 Practitioner shall confirm whether he or she has ever been or is currently subject to being arrested, charged, convicted of or entered a plea for a criminal offense (excluding minor traffic violations), subject to criminal charges involving children, a sexual offense, illegal use of drugs or a crime of moral turpitude.

14.6 Practitioner shall confirm whether he or she has received an adverse quality determination concerning his or her treatment of a patient by a state or federal professional review organization.

15. Practitioner is in good general health.

15.1 Practitioner shall certify on the Application that Practitioner does not have a history of and is not presently abusing drugs or alcohol. A Practitioner with a history of drug or alcohol abuse may be considered for participation in the Health One Network, within the sole and absolute discretion of Health One. In Health One's sole and absolute discretion, Health One may request a Practitioner's personal physician to provide a statement regarding the medical/mental status of the Practitioner and his or her compliance with a rehabilitation, or monitoring program. Practitioner shall execute the necessary authorizations to release the pertinent information to Health One for credentialing purposes.

15.2 Practitioner shall certify on the Application that Practitioner does not have any communicable and/or chronic infectious diseases that may be a potential danger to patients.

NONDISCRIMINATION

16. Practitioner shall pursue and maintain a policy of nondiscrimination. All decisions regarding the treatment of patients should be made without being influenced in any manner by applicant's race, ethnic/national identity, gender, age or sexual orientation.

17. Health One pursues and maintains a policy of nondiscrimination with all practitioners and applicants for panel membership. All decisions regarding panel membership are made without being influenced in any manner by applicant's race, ethnic/national identity, gender, age or sexual orientation.

RECORD REVIEW/AUDITS

18. APRN shall be subject to record reviews, including on site review by HealthOne quality assurance team, medical record review and evaluation to ensure that the required documentation of the acts performed by the APRN are specifically documented in the medical record and conform with the nurse protocol agreement. The APRN and the Supervising/Delegating Physician shall confirm at

credentialing and recredentialing that the following reviews of the patient medical records will be completed in accordance with the following standards:

(1) as applicable to the APRN's scope of practice, a Supervising/Delegating Physician or other designated physician must review and sign 100% of patient records for patients receiving prescriptions for controlled substances to comply with the law.
(2) The Supervising/Delegating Physician must review and sign 100% of patient records in which an adverse outcome has occurred. Review of such record, should occur no more than 30 days after the discovery of the adverse outcome. Health One shall be notified of any adverse or unexpected outcome on a quarterly basis through a report submitted by the delegating physician.
(3) The delegating physician must review and sign 10% of all other patient records. Review of such review shall occur annually.

19. Practitioner shall permit Health One to conduct regular and random on-site audits of his/her practice location, including a review of medical records pertaining to Health One related beneficiaries. Practitioner shall also provide any and all requested documentation to Health One related to the operations of the practice, credentialing materials and response to the audit findings within ten (10) business days upon receipt of the request. Failure to comply with the audits may result in termination or voluntary withdrawal from participation in the Health One Network.

CONTRACT

20. Practitioner shall execute the Health One Practitioner Participation Agreement and abide by the terms of the contract and the full credentialing criteria of Health One.

RELEASE OF INFORMATION

21. Practitioner shall execute the appropriate release to Health One and its agents directing any and all entities that may have information with respect to the ability to practice quality medicine to provide such information to Health One on request. Such entities include, without limitation, hospitals, medical societies, state examining boards, Medicare intermediaries and other third party payers.

    21.1. Practitioner is required to attest via a unique and identifiable electronic or written signature that all of the information submitted is accurate. Provider is further required to authorize Health One to obtain the necessary information from third-parties to complete the credentialing and verification process sufficient to support the credentialing and quality assurance procedures of Health One. Signatures may be electronic in conformance with State law or written original signed copies submitted in paper form.

    21.2. Health One Representatives are authorized by the Credentials Committee to request additional information from the Practitioner and notify them that the application will not be processed unless an accurate and complete application is received within a timely manner. A new application with newly executed releases and attestation statements will be required

in order to process the application. Health One reserves the right to act upon any such findings during the credentialing process. Absence, falsification, or material omission of information requested in the application may be grounds for denial or voluntary withdrawal.

Practitioner has the right to review information submitted to support their credentialing, correct erroneous information, receive the status of their credentialing or recredentialing application, upon request. Health One will respond to a Practitioner's request via phone, fax, letter or email.

VERIFICATION

22. Health One, and its agents, reserves the right to require independent verification of any and all of the Credentialing Criteria.

CHANGES IN INFORMATION NOTIFICATION

23. Practitioner shall be solely responsible for notifying Health One in writing of any changes in the Practitioner's circumstances within three (3) days upon the date of the change in circumstances, including, but not limited to changes in license status, insurance coverage, call coverage, sanctions or changes that would cause any of the information referenced above or submitted through the application to no longer be accurate.

COMPLIANCE

24. Practitioner shall comply with any and all Health One policies and procedures related to the operations and Practitioner participation.

Health One
Initial and Recredentialing Criteria

(Allied)

Chiropractors **(DC)**
Licensed Clinical Social Workers **(LCSW)**
Licensed Marriage and Family Therapist **(LMFT)**
Licensed Professional Counselor **(LPC)**
Master of Social Work **(MSW)**
Physical Therapists **(PT, MPT and DPT)**
Psychologists **(PhD and PsyD)**
Occupational Therapists **(OT)**
Optometrists **(OD)**
Speech Pathologists **(SP and SLP)**
Nurse Practitioners **(NP)**
Certified Nurse Midwives **(CNM)**
Certified Nurse Anesthesists **(CNA)**
Clinical Nurse Specialists **(CNS)**
Physician Assistants **(PA)**

In order to be considered as a Participating Practitioner, Practitioner must establish compliance with the following qualification requirements and responsibilities, as required by Health One and Health One's Credentials Committee. Failure to comply with or satisfy the Health One Network qualification criteria outlined below may result in the Practitioner's voluntary relinquishment, withdrawal or termination from participation in the Health One Network.

For purposes of Medicare and Medicaid plans that Health One serves as a delegated credentialing entity, Health One shall directly credential the midlevel provider as a provider that directly bills for his or her services, as applicable and required by the delegated credentialing obligations of Health One. Otherwise, all other Allied Health Providers that satisfy the Health One criteria shall be processed in accordance with the policy below.

EDUCATION

1. The education requirements for a Participating Practitioner are as follows:

    1.1. Practitioner shall present official documentation indicating he/she has completed an acceptable training program, or postgraduate training from an accredited professional school, as required by the applicable state licensing or registration agency of the Practitioner's profession.

        - Undergraduate Education
        - Medical and/or Professional Education
        - Licensed Professional References
        - Work History

Appendix 1: Credentialing Criteria

LICENSE

2. Practitioner is a person with a current, valid medical license that is not suspended, lapsed, expired or voluntarily surrendered in the State of Georgia and/or any other state in which they actively practice.

DEA

3. Eligible practitioners may hold a current, valid and unrestricted Drug Enforcement Agency (DEA) registration, as appropriate in the State of Georgia and/or any other state in which they actively practice, or provide evidence satisfactory to Health One that the Practitioner does not require such registration in order to deliver appropriate care.

INSURANCE

4. Practitioner shall purchase and maintain, at the sole cost and expense of Practitioner, policies of professional liability in amounts required by Health One. The current minimum amounts set forth by Health One are ONE MILLION DOLLARS ($1,000,000) per occurrence/THREE MILLION DOLLARS ($3,000,000) aggregate. Practitioner shall authorize the carrier to issue to Health One certificate of insurance policies of Practitioner upon request of Health One. Notwithstanding the foregoing, Practitioner shall provide Health One with notification within three (3) days of any cancellation, termination or material alteration of any such insurance policies. Prior to the expiration or cancellation of any such coverage Practitioner shall secure replacement of such insurance coverage upon the same terms, and shall furnish Health One with a certificate of endorsement as described herein. Evidence of the effective policy reflecting such insurance shall be provided with the application.

    MALPRACTICE

    4.1. Details of any professional liability actions that have resulted in adverse judgments or any financial settlements.

    4.2. Details of any pending professional liability actions.

    This information shall be reviewed by Health One. The evaluation shall consider the frequency of such actions, the financial impact of such actions, and the clinical circumstances surrounding the alleged acts of malpractice. Practitioners shall not be automatically disqualified from participation in Health One due to a history of judgments and/or settlements. Each case will be evaluated based on its merits. Health One has sole discretion in the determination of the impact of this information for the purposes of credentialing.

PEER REFERENCES

5. Practitioner shall provide the name, address, phone, fax and email address of three professional peers who can provide reliable information based on significant personal experience as to clinical

ability, ethical character and ability to work with others.

DISCLOSURE

6. Provider shall confirm the following information and provide the necessary documentation and information to enable the Credentials Committee to fully evaluate the Provider's qualifications to participate in the HealthOne Network:

    4.1 Provider shall confirm whether his or her application for clinical privileges or medical staff membership, including a change in staff category at any hospital or healthcare facility has ever been reduced, limited, suspended, terminated or have been placed on probation or restriction or whether he or she has ever resigned to avoid disciplinary action, or investigation or whether any related actions or investigations are pending. Provider shall submit any applicable information regarding the same for review and consideration.

    4.2 Provider shall confirm whether he or she has been the subject of an investigation or Adverse Action and provide any applicable documentation regarding same. "Adverse Action" means a voluntary or involuntary termination, loss of, reduction, withdrawal, limitation, restriction, suspension, revocation, denial or non-renewal of membership, clinical privileges, academic affiliation or appointment, or employment, including any adverse action regarding professional licensure registration, certification, any previously successful or currently pending challenges to such licensure registration or certification.

    4.3 Provider shall confirm whether he or she has been the subject of any report to a state or federal data bank, state licensing or disciplining entity and provide any applicable documentation regarding same.

    4.4 Provider shall confirm whether he or she has ever been suspended, debarred, fined, disciplined, sanctioned or otherwise restricted or excluded from participating in the Medicare or Medicaid program, or any federal, state or private health insurance program.

    4.5 Practitioner shall confirm whether he or she has been convicted of a felony or been convicted of Medicare, Medicaid or other governmental or private third party payor fraud or program abuse or have been required to pay civil penalties for the same.

    4.6 Provider shall confirm whether he or she has ever been or is currently subject to being arrested, charged, convicted of or entered a plea for a criminal offense (excluding minor traffic violations), subject to criminal charges involving children, a sexual offense, illegal use of drugs or a crime of moral turpitude.

    4.7 Provider shall confirm whether he or she has received an adverse quality determination concerning his or her treatment of a patient by a state or federal professional review organization.

7. Practitioner is in good general health.

    7.1. Practitioner shall certify on the Application that Practitioner does not have a history of and is not presently abusing drugs or alcohol. A Practitioner with a history of drug or

alcohol abuse may be considered for participation in the Health One Network, within the sole and absolute discretion of Health One. In Health One's sole and absolute discretion, Health One may request a Practitioner's personal physician to provide a statement regarding the medical/mental status of the Practitioner and his or her compliance with a rehabilitation, or monitoring program. Practitioner shall execute the necessary authorizations to release the pertinent information to Health One for credentialing purposes.

7.2. Practitioner shall certify on the Application that Practitioner does not have any communicable and/or chronic infectious diseases that may be a potential danger to patients.

NONDISCRIMINATION

8. Practitioner shall pursue and maintain a policy of nondiscrimination. All decisions regarding the treatment of patients should be made without being influenced in any manner by applicant's race, ethnic/national identity, gender, age or sexual orientation.

9. Health One pursues and maintains a policy of nondiscrimination with all practitioners and applicants for panel membership. All decisions regarding panel membership are made without being influenced in any manner by applicant's race, ethnic/national identity, gender, age or sexual orientation.

AUDITS

10. Practitioner shall permit Health One to conduct regular and random on-site audits of his/her practice location, including a review of medical records pertaining to Health One related beneficiaries. Practitioner shall also provide any and all requested documentation to Health One related to the operations of the practice, credentialing materials and response to the audit findings within ten (10) business days upon receipt of the request. Failure to comply with the audits may result in termination or voluntary withdrawal from participation in the Health One Network.

CONTRACT

11. Practitioner shall execute the Health One Practitioner Participation Agreement and abide by the terms of the contract and the full credentialing criteria of Health One.

RELEASE OF INFORMATION

12. Practitioner shall execute the appropriate release to Health One and its agents directing any and all entities that may have information with respect to the ability to practice quality medicine to provide such information to Health One on request. Such entities include, without limitation, hospitals, medical societies, state examining boards, Medicare intermediaries and other third party payers.

12.1. Practitioner is required to attest via a unique and identifiable electronic or written signature that all of the information submitted is accurate. Provider is further required to

authorize Health One to obtain the necessary information from third-parties to complete the credentialing and verification process sufficient to support the credentialing and quality assurance procedures of Health One. Signatures may be electronic in conformance with State law or written original signed copies submitted in paper form.

12.2. Health One Representatives are authorized by the Credentials Committee to request additional information from the Practitioner and notify them that the application will not be processed unless an accurate and complete application is received within a timely manner. A new application with newly executed releases and attestation statements will be required in order to process the application. Health One reserves the right to act upon any such findings during the credentialing process. Absence, falsification, or material omission of information requested in the application may be grounds for denial or voluntary withdrawal.

Practitioner has the right to review information submitted to support their credentialing, correct erroneous information, receive the status of their credentialing or recredentialing application, upon request. Health One will respond to a Practitioner’s request via phone, fax, letter or email.

VERIFICATION

13. Health One, and its agents, reserves the right to require independent verification of any and all of the Credentialing Criteria.

CHANGES IN INFORMATION NOTIFICATION

14. Practitioner shall be solely responsible for notifying Health One in writing of any changes in the Practitioner’s circumstances within three (3) days upon the date of the change in circumstances, including, but not limited to changes in license status, insurance coverage, call coverage, sanctions or changes that would cause any of the information referenced above or submitted through the application to no longer be accurate.

COMPLIANCE

15. Practitioner shall comply with any and all Health One policies and procedures related to the operations and Practitioner participation.

Health One
Initial and Recredentialing Criteria

Physicians
(MD, DO, DPM)

In order to be considered as a Participating Practitioner, Practitioner must establish compliance with the following qualification requirements and responsibilities, as required by Health One and Health One's Credentials Committee. Failure to comply with or satisfy the Health One Network qualification criteria outlined below may result in the Practitioner's voluntary relinquishment, withdrawal or termination from participation in the Health One Network.

EDUCATION

1. The education requirements for a Participating Practitioner are as follows:

   1.1 Practitioner must be a graduate of an accredited school of medicine or osteopathy, completed a Residency at an accredited facility and provide complete information with respect to professional training/activities which shall include, without limitation, the following:

   - Undergraduate Education
   - Medical and/or Professional Education
   - Internships and Residencies
   - Fellowships
   - Licensed Professional References
   - Work History

   Health One has the sole discretion with respect to the determination of the acceptability of such credentials.

   1.2 Practitioner must achieve Board Certification within the lesser of seven (7) years from completion of education (Residency/Fellowship) or the eligibility timeframe defined by each specialty's Board, as required by the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), American Board of Foot and Ankle Surgery (ABFAS) or American Dental Board of Oral and Maxillofacial Surgery (ADBOMS); unless Practitioner meets one of the following:

   1.2.1 Practitioner who participated in the Health One Network prior to 1995 who does not hold Board Certification, failed to maintain Board Certification, and is not Board Eligible, may qualify for a Grandfather Waiver of the Board Certification requirements if the Practitioner has exhibited (through evidence to Health One) that he/she has the education, experience and training to provide quality services within Health One. Waivers will be evaluated on a case-by-case basis for participation; or

   1.2.2 Practitioner who failed to maintain Board Certification or Board Eligibility

that has been practicing for at least twenty-five (25) consecutive years of medical service in the same or similar specialty since the completion of their Residency/Fellowship, and have exhibited through evidence to Health One that he/she has the education, experience and training to provide quality services within Health One, will be evaluated on a case-by-case basis as a Participating Practitioner; or

1.2.3 Practitioner is currently Participating in the Health One Network through a Delegated Credentialing Entity and wishes to direct credential with Health One, but is not Board Certified, shall be permitted as a Participating Practitioner, provided the Practitioner is Eligible and obtains Board Certification within twenty-four (24) months upon the granting as a Participating Practitioner through the direct credentialing of the Network. Provided, however Practitioner's delivery of services in the network has not resulted in material adverse outcomes causing a quality of care issue determined by Health One, which shall be evaluated on a case by case basis.

1.3 Practitioner who has a lapse in Board Certification is subject to automatic review.

LICENSE

2. Practitioner must maintain a current, valid medical license that is not suspended, lapsed, expired or voluntarily surrendered in the State of Georgia and/or any other state in which they actively practice. If Practitioner is subject to facility licensure requirements, as set forth by the applicable state laws, Practitioner must maintain a current, valid facility license or permit as required by state law.

DEA

3. Practitioner must hold a current, valid and unrestricted Drug Enforcement Agency (DEA) registration, as appropriate in the State of Georgia and/or any other state in which they actively practice, or provide evidence satisfactory to Health One that the Practitioner does not require such registration in order to deliver appropriate care.

INSURANCE

4. Practitioner shall purchase and maintain, at the sole cost and expense of Practitioner, policies of professional liability in amounts required by Health One. The current minimum amounts set forth by Health One are ONE MILLION DOLLARS ($1,000,000) per occurrence/THREE MILLION DOLLARS ($3,000,000) aggregate. Practitioner shall authorize the carrier to issue to Health One certificate of insurance policies of Practitioner upon request of Health One. Notwithstanding the foregoing, Practitioner shall provide Health One with notification within three (3) days of any cancellation, termination or material alteration of any such insurance policies. Prior to the expiration or cancellation of any such coverage Practitioner shall secure replacement of such insurance coverage upon the same terms, and shall furnish Health One with a certificate of endorsement as described herein. Evidence of the effective policy reflecting such insurance shall be provided with the application.

MALPRACTICE

4.1 Details of any professional liability actions that have resulted in adverse judgments or any financial settlements.

4.2 Details of any pending professional liability actions.

This information shall be reviewed by Health One. The evaluation shall consider the frequency of such actions, the financial impact of such actions, and the clinical circumstances surrounding the alleged acts of malpractice. Practitioners shall not be automatically disqualified from participation in Health One due to a history of judgments and/or settlements. Each case will be evaluated based on its merits. Health One has sole discretion in the determination of the impact of this information for the purposes of credentialing.

ADMITTING PRIVILEGES

5. Practitioner has current and unrestricted admitting privileges, at a participating hospital accredited by a Health One approved Accrediting body; or written evidence that the applicant does not require hospital admitting privileges in order to deliver satisfactory professional services. Practitioners that do not have hospital admitting privileges can submit a Health One Hospital Attestation Form or approved letter which identifies a participating hospitalist, or Practitioner, who practices in the same, or similar, specialty and has agreed to admit Practitioner's patients on Practitioner's behalf. It is within Health One's sole discretion to approve or disapprove these requests based on its assessment in light of patient needs and quality and risk management standards.

5.1 Provider shall confirm whether his or her application for clinical privileges or medical staff membership, including a change in staff category at any hospital or healthcare facility has ever been reduced, limited, suspended, terminated or have been placed on probation or restriction or whether he or she has ever resigned to avoid disciplinary action, or investigation or whether any related actions or investigations are pending. Provider shall submit any applicable information regarding the same for review and consideration.

PEER REFERENCES

6. Practitioner shall provide the name, address, phone, fax and email address of three professional peers who can provide reliable information based on significant personal experience as to clinical ability, ethical character and ability to work with others.

CALL COVERAGE

7. In order to assure continuous and quality care to patients, Participating Practitioner in the Health One Network shall provide coverage consistent with the guidelines set forth

below for times when they are absent from their medical practice. Notwithstanding the below, it is in Health One's sole and absolute discretion, based on its assessment of the coverage proposal considering patient needs and quality and risk management standards, to approve or disapprove such alternative coverage requests.

7.1 Practitioner must have made arrangements to allow patients and other practitioners to contact Practitioner (or covering provider) 24 hours a day, 7 days a week. Automatic referrals to the emergency department shall not satisfy the call coverage obligations of a Participating Practitioner.

7.2 To ensure continuity of patient care, Practitioner must have made arrangements with a Participating Practitioner or group to provide call coverage on a 24 hours a day, and 7 days a week basis to respond to all calls in a prompt manner.

7.3 Call Coverage must be provided by a licensed Practitioner who (i) practices in the same or similar specialty as deemed reasonable by Health One and (ii) is capable of providing services of an urgent or emergency nature which the Practitioner being covered would typically provide for patients in his/her practice. The covering Practitioner is to be a physician that is a Participating Practitioner with Health One, or the Practitioner for whom call coverage service is being provided must bill for services rendered by the call covering Practitioner through his/her own Tax ID through a bona-fide locums tenens arrangement when the Participating Practitioner is unavailable

7.4 If a Practitioner cannot secure coverage from a Participating Practitioner in the same or similar specialty and the Practitioner practices in a Rural Area, as defined herein, the Practitioner must submit a request in writing to Health One for coverage by another Practitioner who can provide the appropriate level of services to cover for the requesting Practitioner or for a hardship waiver of the coverage requirements. *Rural Area* means an area that is not an Urban Area as defined A Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA), as defined by the Executive Office of Management and Budget, excluding Whitfield and Murray Counties, Georgia. Health One will consider all such exception requests in a timely manner. In addition, depending upon the patient needs to access healthcare services in the Rural Area, Health One may grant an exception to ensure access to healthcare services for the beneficiaries that receive care from HealthOne Participating Practitioner.

7.5 Failure by a Practitioner to comply strictly with this policy will result in a written warning being issued to the offending Practitioner by Health One wherein the Participating Practitioner shall have ten (10) days to provide a written plan to cure the deficiency. If Practitioner fails to cure the deficiency within thirty (30) days or a time period that is deemed reasonable by Health One, upon submission of the written plan to cure the deficiency, Practitioner shall fail to maintain qualifications to be eligible as a Participating Practitioner and such participation shall automatically terminate and be deemed voluntarily withdrawn.

7.6 Decisions on Practitioner participation with the Health One Network or termination

of a Participation Agreement based on this Call Coverage Policy involve the business objectives of Health One and not matters of professional competence. Failure to obtain and maintain call coverage will be deemed a voluntary withdrawal from the Health One Network for failure to satisfy the qualification criteria, and therefore, no rights of appeal or national databank reports will be applicable to such decisions.

DISCLOSURE

8. Provider shall confirm the following information and provide the necessary documentation and information to enable the Credentials Committee to fully evaluate the Provider's qualifications to participate in the HealthOne Network:

   8.1 Provider shall confirm whether he or she has been the subject of an investigation or Adverse Action and provide any applicable documentation regarding same. "Adverse Action" means a voluntary or involuntary termination, loss of, reduction, withdrawal, limitation, restriction, suspension, revocation, denial or non-renewal of membership, clinical privileges, academic affiliation or appointment, or employment, including any adverse action regarding professional licensure registration, certification, any previously successful or currently pending challenges to such licensure registration or certification.

   8.2 Provider shall confirm whether he or she has been the subject of any report to a state or federal data bank, state licensing or disciplining entity and provide any applicable documentation regarding same.

   8.3 Provider shall confirm whether he or she has ever been suspended, debarred, fined, disciplined, sanctioned or otherwise restricted or excluded from participating in the Medicare or Medicaid program, or any federal, state or private health insurance program.

   8.4 Practitioner has not been convicted of a felony or been convicted of Medicare, Medicaid or other governmental or private third party payor fraud or program abuse or have been required to pay civil penalties for the same.

   8.5 Provider shall confirm whether he or she has ever been or is currently subject to being arrested, charged, convicted of or entered a plea for a criminal offense (excluding minor traffic violations), subject to criminal charges involving children, a sexual offense, illegal use of drugs or a crime of moral turpitude.

   8.6 Provider shall confirm whether he or she has received an adverse quality determination concerning his or her treatment of a patient by a state or federal professional review organization.

9. Practitioner is in good general health.

   9.1 Practitioner shall certify on the Application that Practitioner does not have a history of and is not presently abusing drugs or alcohol. A Practitioner with a

history of drug or alcohol abuse may be considered for participation in the Health One Network, within the sole and absolute discretion of Health One. In Health One's sole and absolute discretion, Health One may request a Practitioner's personal physician to provide a statement regarding the medical/mental status of the Practitioner and his or her compliance with a rehabilitation, or monitoring program. Practitioner shall execute the necessary authorizations to release the pertinent information to Health One for credentialing purposes.

9.2 Practitioner shall certify on the Application that Practitioner does not have any communicable and/or chronic infectious diseases that may be a potential danger to patients.

NONDISCRIMINATION

10. Practitioner shall pursue and maintain a policy of nondiscrimination. All decisions regarding the treatment of patients should be made without being influenced in any manner by applicant's race, ethnic/national identity, gender, age or sexual orientation.

11. Health One pursues and maintains a policy of nondiscrimination with all practitioners and applicants for panel membership. All decisions regarding panel membership are made without being influenced in any manner by applicant's race, ethnic/national identity, gender, age or sexual orientation.

AUDITS

12. Practitioner shall permit Health One to conduct regular and random on-site audits of his/her practice location, including a review of medical records pertaining to Health One related beneficiaries. Practitioner shall also provide any and all requested documentation to Health One related to the operations of the practice, credentialing materials and response to the audit findings within ten (10) business days upon receipt of the request. Failure to comply with the audits may result in termination or voluntary withdrawal from participation in the Health One Network.

CONTRACT

13. Practitioner shall execute the Health One Practitioner Participation Agreement and abide by the terms of the contract and the full credentialing criteria of Health One.

RELEASE OF INFORMATION

14. Practitioner shall execute the appropriate release to Health One and its agents directing any and all entities that may have information with respect to the ability to practice quality medicine to provide such information to Health One on request. Such entities include, without limitation, hospitals, medical societies, state examining boards, Medicare intermediaries and other third party payers.

14.1. Practitioner is required to attest via a unique and identifiable electronic or written signature that all of the information submitted is accurate. Provider is further required to authorize Health One to obtain the necessary information from third-parties to complete the credentialing and verification process sufficient to support the credentialing and quality assurance procedures of Health One. Signatures may be electronic in conformance with State law or written original signed copies submitted in paper form.

14.2. Health One Representatives are authorized by the Credentials Committee to request additional information from the Practitioner and notify them that the application will not be processed unless an accurate and complete application is received within a timely manner. A new application with newly executed releases and attestation statements will be required in order to process the application. Health One reserves the right to act upon any such findings during the credentialing process. Absence, falsification, or material omission of information requested in the application may be grounds for denial or voluntary withdrawal.

Practitioner has the right to review information submitted to support their credentialing, correct erroneous information, receive the status of their credentialing or recredentialing application, upon request. Health One will respond to a Practitioner's request via phone, fax, letter or email.

VERIFICATION

15. Health One, and its agents, reserves the right to require independent verification of any and all of the Credentialing Criteria.

CHANGES IN INFORMATION NOTIFICATION

16. Practitioner shall be solely responsible for notifying Health One in writing of any changes in the Practitioner's circumstances within three (3) days upon the date of the change in circumstances, including, but not limited to changes in license status, insurance coverage, call coverage, sanctions or changes that would cause any of the information referenced above or submitted through the application to no longer be accurate.

COMPLIANCE

17. Practitioner shall comply with any and all Health One policies and procedures related to the operations and Practitioner participation.

Health One

Initial and Recredentialing Criteria

Attachment 1

Federally Qualified Health Centers

In order to be considered a Participating Federally Qualified Health Center Provider (FQHC), as an essential community provider, Provider must notify Health One of their FQHC status and verify compliance with the following qualification requirements and responsibilities, as required by Health One and Health One's Credentials Committee. Failure to comply with or satisfy the Health One Network qualification criteria outlined below may result in the Practitioner's voluntary relinquishment, withdrawal or termination from participation in the Health One Network.

REGULATORY REQUIREMENTS

1. Provider must maintain a written agreement with the Centers for Medicare and Medicaid Services (CMS) to serve as an FQHC.

2. Provider must receive a grant under §330 of the Public Health Service (PHS) Act; or receives funding under a contract with the recipient of a §330 grant, and meets the requirements to receive a grant under §330 of the PHS Act; or (a) has been notified in writing that the facility meets the requirements for receiving a §330 grant, even though it is not actually receiving such a grant; or (b) was a comprehensive federally funded health center as of January 1, 1990; or (c) is an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act or by an Urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act.

3. FQHC shall provider written evidence that it satisfied the two qualification criteria described above.

Health One

Initial and Recredentialing Criteria

Organizational Providers

In order to be considered a Participating Organizational Provider, Provider must establish compliance with the following qualification requirements and responsibilities, as required by Health One and Health One's Credentials Committee. Failure to comply with or satisfy the Health One Network qualification criteria outlined below may result in the Practitioner's voluntary relinquishment, withdrawal or termination from participation in the Health One Network.

ACCREDITATION

1. Provider must attain Accreditation in accordance with one of the Health One approved Accrediting Bodies as appropriate for their provider type.

LICENSE

2. Provider must hold a current, valid and unrestricted facility license or facility permit as appropriate for the State of Georgia and/or any other state in which they actively render services. Providers must hold a current, valid and unrestricted facility license in the State of Georgia in order to dispense or provide any clinical services to Georgia residents, unless the State of Georgia does not maintain a license or certification requirement for the provider type.

DEA

3. Provider must hold a current, valid and unrestricted Drug Enforcement Agency (DEA) registration, as appropriate in the State of Georgia and/or any other state in which they actively render services, or provide evidence satisfactory to Health One that the Provider does not require such registration in order to deliver appropriate care.

INSURANCE

4. Provider shall purchase and maintain, at the sole cost and expense of Provider, policies of professional and/or general liability in amounts required by Health One. The current minimum amounts set forth by Health One are ONE MILLION DOLLARS ($1,000,000) per occurrence/THREE MILLION DOLLARS ($3,000,000) aggregate. Provider shall authorize the carrier to issue to Health One certificate of insurance policies of Provider upon request of Health One. Notwithstanding the foregoing, Provider shall provide Health One with notification within three (3) days of any cancellation, termination or material alteration of any such insurance policies. Prior to the expiration or cancellation of any such coverage Provider shall secure replacement of such insurance coverage upon the same terms, and shall furnish Health One with a certificate of endorsement as described herein. Evidence of the effective policy reflecting such insurance shall be provided with the application.

MALPRACTICE

4.1 Details of any professional and/or general liability actions that have resulted in adverse judgments or any financial settlements.

4.2 Details of any pending professional and/or general liability actions.

This information shall be reviewed by Health One. The evaluation shall consider the frequency of such actions, the financial impact of such actions, and the clinical circumstances surrounding the alleged acts of malpractice. Providers shall not be automatically disqualified from participation in Health One due to a history of judgments and/or settlements. Each case will be evaluated based on its merits. Health One has sole discretion in the determination of the impact of this information for the purposes of credentialing.

DISCLOSURE

5. Provider shall confirm the following information and provide the necessary documentation and information to enable the Credentials Committee to fully evaluate the Provider's qualifications to participate in the HealthOne Network:

5.1 Provider shall confirm if anyone in the Provider's staff has been the subject of any report to a state or federal data bank, state licensing or disciplining entity and provide any applicable documentation regarding same.

5.2 Provider shall confirm whether Provider or its authorized representatives has ever been suspended, debarred, fined, disciplined, sanctioned or otherwise restricted or excluded from participating in the Medicare or Medicaid program, or any federal, state or private health insurance program.

5.3 Provider or its authorized representatives have not been convicted of a felony or been convicted of Medicare, Medicaid or other governmental or private third party payor fraud or program abuse or have been required to pay civil penalties for the same.

5.4 Provider shall confirm whether criminal proceedings have ever been initiated against the Providers or its authorized representatives.

5.5 Provider or its authorized representatives shall confirm whether any adverse quality determination concerning Provider treatment of a patient by a state or federal professional review organization.

6. Practitioner is in good general health.

6.1 Practitioner shall certify on the Application that Practitioner does not have a history of and is not presently abusing drugs or alcohol. A Practitioner with a history of drug or alcohol abuse may be considered for participation in the Health One Network, within the sole and absolute discretion of Health One. In Health One's

sole and absolute discretion, Health One may request a Practitioner's personal physician to provide a statement regarding the medical/mental status of the Practitioner and his or her compliance with a rehabilitation, or monitoring program. Practitioner shall execute the necessary authorizations to release the pertinent information to Health One for credentialing purposes.

6.2 Practitioner shall certify on the Application that Practitioner does not have any communicable and/or chronic infectious diseases that may be a potential danger to patients.

NONDISCRIMINATION

7. Provider shall pursue and maintain a policy of nondiscrimination. All decisions regarding the treatment of patients should be made without being influenced in any manner by applicant's race, ethnic/national identity, gender, age or sexual orientation.

8. Health One pursues and maintains a policy of nondiscrimination with all providers and applicants for panel membership. All decisions regarding panel membership are made without being influenced in any manner by applicant's race, ethnic/national identity, gender, age or sexual orientation.

AUDITS

9. Provider shall permit Health One to conduct regular and random on-site audits, including a review of medical records pertaining to Health One related beneficiaries. Provider shall also provide any and all requested documentation to Health One related to the operations of the practice, credentialing materials and response to the audit findings within ten (10) business days upon receipt of the request. Failure to comply with the audits may result in termination or voluntary withdrawal from participation in the Health One Network.

CONTRACT

10. Provider shall execute the Health One Provider Participation Agreement and abide by the terms of the contract and the full credentialing criteria of Health One.

RELEASE OF INFORMATION

11. Provider shall execute the appropriate release to Health One and its agents directing any and all entities that may have information with respect to the ability to practice quality medicine to provide such information to Health One on request. Such entities include, without limitation, hospitals, medical societies, state examining boards, Medicare intermediaries and other third party payers.

11.1 Provider is required to attest via a unique and identifiable electronic or written signature that all of the information submitted is accurate. Provider is further required to authorize Health One to obtain the necessary information from third-parties to complete the credentialing and verification process sufficient to support

the credentialing and quality assurance procedures of Health One. Signatures may be electronic in conformance with State law or written original signed copies submitted in paper form.

11.2 Health One Representatives are authorized by the Credentials Committee to request additional information from the Provider and notify them that the application will not be processed unless an accurate and complete application is received within a timely manner. A new application with newly executed releases and attestation statements will be required in order to process the application. Health One reserves the right to act upon any such findings during the credentialing process. Absence, falsification, or material omission of information requested in the application may be grounds for denial or voluntary withdrawal.

Provider has the right to review information submitted to support their credentialing, correct erroneous information, receive the status of their credentialing or recredentialing application, upon request. Health One will respond to a Provider's request via phone, fax, letter or email.

VERIFICATION

12. Health One, and its agents, reserves the right to require independent verification of any and all of the Credentialing Criteria.

CHANGES IN INFORMATION NOTIFICATION

13. Provider shall be solely responsible for notifying Health One in writing of any changes in the Provider's circumstances within three (3) days upon the date of the change in circumstances, including, but not limited to changes in facility license/permit status, DEA certificate, insurance coverage, sanctions or changes that would cause any of the information referenced above or submitted through the application to no longer be accurate.

COMPLIANCE

14. Provider shall comply with any and all Health One policies and procedures related to the operations and Provider participation.

Health One

Initial and Recredentialing Criteria

Urgent Care Physicians
(MD, DO)

In order to be considered as a Participating Practitioner, Practitioner must establish compliance with the following qualification requirements and responsibilities, as required by Health One and Health One's Credentials Committee. Failure to comply with or satisfy the Health One Network qualification criteria outlined below may result in the Practitioner's voluntary relinquishment, withdrawal or termination from participation in the Health One Network.

Definition of "Urgent Care":
The below guidelines must apply:

1. Charge urgent care copay
2. Open extended hours (office opens prior to 8 am and/or is open 6:00 pm or later/weekends)
3. Bill Place of Service 20 (urgent care)

Important Note: Physicians can NOT practice outside the Urgent Care center without having hospital admitting privileges and call coverage.

EDUCATION

1. The education requirements for a Participating Practitioner are as follows:

   1.1 Practitioner must be a graduate of an accredited school of medicine or osteopathy, completed Residency at an accredited facility and provide complete information with respect to professional training/activities which shall include, without limitation, the following:

   - Undergraduate Education
   - Medical and/or Professional Education
   - Internships and Residencies
   - Fellowships
   - Licensed Professional References
   - Work History

   Health One has the sole discretion with respect to the determination of the acceptability of such credentials.

   1.2 Practitioner must achieve Board Certification within the lesser of seven (7) years from completion of education (Residency/Fellowship) or the eligibility timeframe defined by each specialty's Board, as required by the American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA); unless Practitioner meets one of the following:

   1.2.1 Practitioner who participated in the Health One Network prior to 1995 who

does not hold Board Certification, failed to maintain Board Certification, and is not Board Eligible, may qualify for a Grandfather Waiver of the Board Certification requirements if the Practitioner has exhibited (through evidence to Health One) that he/she has the education, experience and training to provide quality services within Health One. Waivers will be evaluated on a case-by-case basis for participation; or

1.2.2 Practitioner who failed to maintain Board Certification or Board Eligibility that has been practicing for at least twenty-five (25) consecutive years of medical service in the same or similar specialty since the completion of their Residency/Fellowship, and have exhibited through evidence to Health One that he/she has the education, experience and training to provide quality services within Health One, will be evaluated on a case-by-case basis as a Participating Practitioner; or

1.2.3 Practitioner is currently Participating in the Health One Network through a Delegated Credentialing Entity and wishes to direct credential with Health One, but is not Board Certified, shall be permitted as a Participating Practitioner, provided the Practitioner is Eligible and obtains Board Certification within twenty-four (24) months upon the granting as a Participating Practitioner through the direct credentialing of the Network. Provided, however Practitioner's delivery of services in the network has not resulted in material adverse outcomes causing a quality of care issue determined by Health One, which shall be evaluated on a case by case basis.

1.3 Practitioner who has a lapse in Board Certification is subject to automatic review.

<u>LICENSE</u>

2. Practitioner is a person with a current, valid medical license that is not suspended, lapsed, expired or voluntarily surrendered in the State of Georgia and/or any other state in which they actively practice.

<u>DEA</u>

3. Practitioner must hold a current, valid and unrestricted Drug Enforcement Agency (DEA) registration, as appropriate in the State of Georgia and/or any other state in which they actively practice, or provide evidence satisfactory to Health One that the Practitioner does not require such registration in order to deliver appropriate care.

<u>INSURANCE</u>

4. Practitioner shall purchase and maintain, at the sole cost and expense of Practitioner, policies of professional liability in amounts required by Health One. The current minimum amounts set forth by Health One are ONE MILLION DOLLARS ($1,000,000) per occurrence/THREE MILLION DOLLARS ($3,000,000) aggregate. Practitioner shall authorize the carrier to issue to Health One certificate of insurance policies of Practitioner upon request of Health One. Notwithstanding the foregoing, Practitioner

shall provide Health One with notification within three (3) days of any cancellation, termination or material alteration of any such insurance policies. Prior to the expiration or cancellation of any such coverage Practitioner shall secure replacement of such insurance coverage upon the same terms, and shall furnish Health One with a certificate of endorsement as described herein. Evidence of the effective policy reflecting such insurance shall be provided with the application.

MALPRACTICE

4.1 Details of any professional liability actions that have resulted in adverse judgments or any financial settlements.

4.2 Details of any pending professional liability actions.

This information shall be reviewed by Health One. The evaluation shall consider the frequency of such actions, the financial impact of such actions, and the clinical circumstances surrounding the alleged acts of malpractice. Practitioners shall not be automatically disqualified from participation in Health One due to a history of judgments and/or settlements. Each case will be evaluated based on its merits. Health One has sole discretion in the determination of the impact of this information for the purposes of credentialing.

ADMITTING PRIVILEGES

Not required for this provider category

PEER REFERENCES

5. Practitioner shall provide the name, address, phone, fax and email address of three professional peers who can provide reliable information based on significant personal experience as to clinical ability, ethical character and ability to work with others.

CALL COVERAGE

Not required for this provider category)see Michele’s version

DISCLOSURE

8. Provider shall confirm the following information and provide the necessary documentation and information to enable the Credentials Committee to fully evaluate the Provider’s qualifications to participate in the HealthOne Network:

8.1 Provider shall confirm whether he or she has been the subject of an investigation or Adverse Action and provide any applicable documentation regarding same. “Adverse Action” means a voluntary or involuntary termination, loss of, reduction, withdrawal, limitation, restriction, suspension, revocation, denial or non-renewal of

membership, clinical privileges, academic affiliation or appointment, or employment, including any adverse action regarding professional licensure registration, certification, any previously successful or currently pending challenges to such licensure registration or certification.

8.2 Provider shall confirm whether he or she has been the subject of any report to a state or federal data bank, state licensing or disciplining entity and provide any applicable documentation regarding same.

8.3 Provider shall confirm whether he or she has ever been suspended, debarred, fined, disciplined, sanctioned or otherwise restricted or excluded from participating in the Medicare or Medicaid program, or any federal, state or private health insurance program.

8.4 Practitioner has not been convicted of a felony or been convicted of Medicare, Medicaid or other governmental or private third party payor fraud or program abuse or have been required to pay civil penalties for the same.

8.5 Provider shall confirm whether he or she has ever been or is currently subject to being arrested, charged, convicted of or entered a plea for a criminal offense (excluding minor traffic violations), subject to criminal charges involving children, a sexual offense, illegal use of drugs or a crime of moral turpitude.

8.6 Provider shall confirm whether he or she has received an adverse quality determination concerning his or her treatment of a patient by a state or federal professional review organization.

9. Practitioner is in good general health.

9.1 Practitioner shall certify on the Application that Practitioner does not have a history of and is not presently abusing drugs or alcohol. A Practitioner with a history of drug or alcohol abuse may be considered for participation in the Health One Network, within the sole and absolute discretion of Health One. In Health One's sole and absolute discretion, Health One may request a Practitioner's personal physician to provide a statement regarding the medical/mental status of the Practitioner and his or her compliance with a rehabilitation, or monitoring program. Practitioner shall execute the necessary authorizations to release the pertinent information to Health One for credentialing purposes.

9.2 Practitioner shall certify on the Application that Practitioner does not have any communicable and/or chronic infectious diseases that may be a potential danger to patients.

NONDISCRIMINATION

10. Practitioner shall pursue and maintain a policy of nondiscrimination. All decisions

regarding the treatment of patients should be made without being influenced in any manner by applicant's race, ethnic/national identity, gender, age or sexual orientation.

11. Health One pursues and maintains a policy of nondiscrimination with all practitioners and applicants for panel membership. All decisions regarding panel membership are made without being influenced in any manner by applicant's race, ethnic/national identity, gender, age or sexual orientation.

AUDITS

12. Practitioner shall permit Health One to conduct regular and random on-site audits of his/her practice location, including a review of medical records pertaining to Health One related beneficiaries. Practitioner shall also provide any and all requested documentation to Health One related to the operations of the practice, credentialing materials and response to the audit findings within ten (10) business days upon receipt of the request. Failure to comply with the audits may result in termination or voluntary withdrawal from participation in the Health One Network.

CONTRACT

13. Practitioner shall execute the Health One Practitioner Participation Agreement and abide by the terms of the contract and the full credentialing criteria of Health One.

RELEASE OF INFORMATION

14. Practitioner shall execute the appropriate release to Health One and its agents directing any and all entities that may have information with respect to the ability to practice quality medicine to provide such information to Health One on request. Such entities include, without limitation, hospitals, medical societies, state examining boards, Medicare intermediaries and other third party payers.

    14.1. Practitioner is required to attest via a unique and identifiable electronic or written signature that all of the information submitted is accurate. Provider is further required to authorize Health One to obtain the necessary information from third-parties to complete the credentialing and verification process sufficient to support the credentialing and quality assurance procedures of Health One. Signatures may be electronic in conformance with State law or written original signed copies submitted in paper form.

    14.2. Health One Representatives are authorized by the Credentials Committee to request additional information from the Practitioner and notify them that the application will not be processed unless an accurate and complete application is received within a timely manner. A new application with newly executed releases and attestation statements will be required in order to process the application. Health One reserves the right to act upon any such findings during the credentialing process. Absence, falsification, or material omission of information requested in the application may be grounds for denial or voluntary withdrawal.

Practitioner has the right to review information submitted to support their credentialing, correct erroneous information, receive the status of their credentialing or recredentialing application, upon request. Health One will respond to a Practitioner's request via phone, fax, letter or email.

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CHANGES IN INFORMATION NOTIFICATION

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COMPLIANCE

17. Practitioner shall comply with any and all Health One policies and procedures related to the operations and Practitioner participation.

Language Assistance

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Alliant Health Plans, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al (800) 811-4793.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Alliant Health Plans, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi (800) 811-4793.

만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Alliant Health Plans 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는(800) 811-4793 로 전화하십시오.

如果您，或是您正在協助的對象，有關於[插入SBM項目的名稱Alliant Health Plans]方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 (800) 811-4793。

જો તમે અથવા તમે કોઇને મદદ કરી રહ્ાાં તેમ ાંથી કોઇને [એસબીએમ ક ર્યક્રમન ાં ન મ મ કો] વિશે પ્રશ્નો હોર્ તો તમને મદદ અને મ હહતી મેળિ નો અવિક ર છે. તે ખર્ય વિન તમ રી ભ ષ મ ાં પ્ર પ્ત કરી શક ર્ છે. દુભ વષર્ો િ ત કરિ મ ટે,આ [અહીં દ ખલ કરો નાંબર] પર કોલ કરો(800) 811-4793.

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Alliant Health Plans, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez (800) 811-4793.

እርስዎ፣ወይም እርስዎ የሚያግዙትግለሰብ፣ ስለAlliant Health Plansጥያቄ ካላችሁ፣ ያለ ምንም ክፍያበቋ ንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። ከአስተርጓሚ ጋር ለመነጋገር፣(800) 811-4793 ይደውሉ።

यदि आपके ,या आप द्वारा सहायता ककए जा रहे ककसी व्यक्तत के Alliant Health Plans के बारे में प्रश्न हैं ,तो आपके पास अपनी भाषा में मुफ्त में सहायता और सूचना प्राप्त करने का अधिकार है। ककसी िुभाषिए से बात करने के लिए, (800) 811-4793 पर कॉि करें।

Si oumenm oswa yon moun w ap ede gen kesyon konsènan Alliant Health Plans, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan (800) 811-4793.

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Alliant Health Plans, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону (800) 811-4793.

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Alliant Health Plans ، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل ب (800) 811-4793.

Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Alliant Health Plans, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para (800) 811-4793.

اگر شما، اي کسی که شما به او کمک میکنید ، سوال در مورد Alliant Health Plans، داشته باشید حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید (800) 811-4793. تماس حاصل نمایید

Falls Sie oder jemand, dem Sie helfen, Fragen zum Alliant Health Plans haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer (800) 811-4793 an.

ご本人様、またはお客様の身の回りの方でも Alliant Health Plans についてご質問がござ いましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、(800) 811-4793までお電話ください。

Non-Discrimination

Alliant Health Plans does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefit determinations.

TTY/TDD

ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call 1-(800) 811-4793 (TTY/TDD: 1-(800) 811-4793).